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ABSTRACT

A study examined the effectiveness of existing nursing education programs to prepare individuals in the United Kingdom for employment as community specialist practitioners in the context of public health. The study was designed in three strands as follows: (1) a questionnaire-based source of 52 directors and leaders from community specialist programs; (2) a survey of 109 senior nurses across England; and (3) focus groups, interviews of 76 individuals, and document analyses to determine the relationship between education and practice. Community specialist practitioners did not generally see public health work as "core" work. Community specialist roles were in transition. Prior experience in community settings was deemed important in further learning about public health work. It was suggested that interdisciplinary learning be incorporated into curricula to provide a strong base for collaborative working and that developments in practice-based learning and assessment be transferred from other settings to address issues raised in relation to community specialist courses. (Contains 11 tables/figures and 69 references. The following are among the items appended: information on those interviewed; examples of public health practice in health visiting, district nursing, and practice nursing; standards outlined in the feasibility study on national standards for specialist practice in public health; and the questionnaires.) (MN)

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ED 463 402

EVALUATION OF THE DEVELOPING SPECIALIST PRACTITIONER ROLE IN THE CONTEXT OF PUBLIC HEALTH

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EVALUATION OF THE DEVELOPING SPECIALIST PRACTITIONER ROLE IN THE CONTEXT OF PUBLIC HEALTH

(PART FUNDED BY THE UKCC)

PREFACE

The Board is pleased to publish this report which was commissioned to examine the educational preparation of community specialist practitioners in response to developments in policy and practice. The focus of the research was on the contribution of health visitors, district nurses and practice nurses in public health and the education needed to meet increasingly complex roles. The study was undertaken in three stages and evidence was obtained through surveys and case studies in four districts to explore the translation of education into practice.

The findings emerging from this exploratory study show that public health work is not necessarily perceived as central to the work of nurses. The value of learning within practice is emphasised and the need to prioritise the long term benefits of the contribution of nurses within public health is a significant finding. The findings emerging from this report are of particular importance to all managers, educationalists and practitioners concerned with the education and practice of nurses within the field of public health.

Through a variety of means the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension in the development of policy. The educational implications contained within this report have been considered in relation to policy.

Professor Ron De Witt
Chairman of the Board

Professor Jeff Thompson
Chairman of Research and Development
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Executive Summary

Purpose of Study

This study seeks to determine how far community specialist practitioners are being prepared to meet relevant standards and, in particular, how far they are able to achieve public health agendas in practice. The study aimed

- To evaluate the effectiveness as demonstrated in practice, of the key learning outcomes of a range of specialist practitioner programmes
- To explore the developmental implications for the role of the specialist practitioner in the context of public health
- To analyse the implications of developments in post-registration education for pre-registration education and practice

Background

Public health work can be defined as the promotion and maintenance of health within a given population. There are two dominant models of public health. One is constructed around the medical model, and looks in the main at individuals' behaviour, focusing on the responsibility of each individual to contribute to preventing disease and improving health targets. The second centres around community development ideas such as empowerment, and uses a salutogenic model of health in which the key to a healthy population is that it has the resources for health. Both are of relevance in current policy.

Promoting and maintaining the health of the public is now central to government policy. The publication of a series of green and white papers has reinforced this, and emphasised the importance both of communities and of primary health care as a setting for public health work. The contribution of nurses, midwives and health visitors to the process of creating and promoting the health and well-being of the populations they serve has been confirmed in the public health White Paper. The educational preparation of community nurses to undertake roles in public health is of central importance for the future.

An overview of literature concerned with public health nursing education and practice is presented. It begins by looking at the nature of public health work in nursing. The knowledge and skills required for community health nursing practice, including public health nursing are discussed. These are set alongside proposed multi-disciplinary standards for specialist practice in public health. It is noted that nurses entering post-registration programmes are, increasingly, prepared in a different way to their predecessors. The findings of the UKCC's Commission to review initial preparation for nursing are briefly reported.

Study Design

The study was designed in three strands. The first two, a study of courses and practice settings, sought to provide a broad overview of developments in the development of public health nursing. The third strand used a multiple case design, with each case

selected to offer a different perspective on the phenomenon of 'education into practice', bringing together educational and practice settings, practitioners and students, to allow a more detailed exploration of the processes of curriculum delivery and practice development.

Strand One

Strand One was a questionnaire based survey of course programme directors (n=10) and route module leaders (n=42) from community specialist programmes. The response rate ranged from 29% for Course Programme Directors to 44% overall for Route Module Leaders. The main priority for educationalists was about targeting poverty and inequity in terms of employment, housing, education and health care provision. Health promotion was a strong common theme for all but the route module leaders for district nursing. Programme strengths were identified as rooted in shared learning through inter-professional collaboration and good clinical links with community practitioners and community practice teachers. However, the main weaknesses identified appeared to be around the problems of integrating theory and practice. Shortage of time to deliver the programme adequately was seen as adding to this difficulty. National policy documents featured most strongly as influencing preparation, however, a range of literature from professional and educational bodies was also mentioned. The strongest identifiable public health function across all disciplines was health needs assessment. However, between the disciplines there was great variation.

Strand Two

Strand Two collected the views of senior nurses in each Health Authority and Trust in England (n=109) about public health work in community specialist nursing. The response rates across Regions ranged from excellent at 64% to extremely poor at 23%. The data mainly reflects the views of senior nurses working in Trust environments. The major influence in determining public health priorities was seen as the information and direction received through national documentation. Local priorities were often determined through targeting of specific groups, pregnant teenagers and ethnic minorities or refugees often featuring strongly. The key functions of the public health nursing role were seen as health needs assessment, health promotion and service and policy development. Obstacles and opportunities in the work environment were also explored for each group. Public health posts in practice were identified as including both specialist posts (for example TB nurses, AIDs specialists, accident prevention health visitors, infection control and communicable disease nurses mainly, but a large range of posts mentioned) and 'community nursing' posts (mainly described in terms of health visiting and school nursing, although district nursing was mentioned). Education and resource availability featured as both barriers (if lacking) and facilitators to achieving successful public health nursing work.

Strand Three

For Strand Three of the study data was gathered at each site using focus groups and individual interviews (n=76) as well as public health incident logs, curriculum documents and local policy documents. The data gathered looked at respondents

perceptions of public health, the nature of the educational experience of the students in relation to public health, and the way in which this was translated into practice, together with the factors which acted as barriers or levers in the latter. At all sites, respondents found it difficult to articulate what public health work might be, though all the practitioners provided examples of public health practice in the logs. The balance between University based work and learning in practice was seen as important, with the models of public health available in the practice setting seen as central to learning. Community Practice Teachers were seen as a key influence on students' practice, but in their own practice struggled to balance public health work with other responsibilities. Public health work was seen by them as 'add-on' work, not highly valued by colleagues and managers. Time was seen as a major constraint to effective learning.

Outlining their concept of 'public health' proved to be a challenge for almost all respondents. Responses could be described on two axes. The first of these lay between individual and collective activity. The second spanned a continuum from infection control or 'hygiene' on the one hand to community empowerment on the other. Despite difficulties in explaining exactly what public health might mean as a concept, a majority of the respondents appeared to have no difficulty in completing a practice log describing public health activity which they were involved. The major barrier to undertaking public health practice was seen as the pressure to undertake mainstream, 'hands on', practice. The Community Practice Teacher was seen as having a key role in bridging the theory-practice gap, and helping students to see how University based teaching made sense in the practice context. An outline model is described which, it is suggested, offers a way of describing the inter-relationship between factors identified at different points in the educational process as impacting on learning about public health work.

Discussion

A number of issues arise from the findings reported above. Public health work is not generally seen as 'core' work by community specialist practitioners, even health visitors. It tends to take second place to mainstream practice and areas of work which are more concretely measurable. The reader is asked how can the status of public health be raised, and in particular, where resources are finite, how can public health work be supported alongside more immediate health care demands?

The concept of public health is constantly changing. This requires those working in public health to possess skills which can grow and develop to meet needs as they emerge - flexible and transferable skills. In addition, the environment in which learning takes place and the resources available must be assessed in the light of current approaches to public health. Course Programme Directors and others will need to address how best curricula can enable practitioners to obtain a flexible portfolio of skills.

Community specialist roles remain in transition. Different disciplines have different perceptions of public health, suggesting that they might apply core skills in different ways. A review should examine how far the core skills required are held and used in common. Students learn to do public health work through learning to see 'the wider

picture'. Though Community Practice Teachers appear more influential in shaping public health practice than lecturers, they are not always supported in this task. Further work is required to explore how this is best done. In addition, post-qualification support in developing practice must be addressed.

Conclusion

This study has examined how far programmes of education can successfully prepare community nursing specialist practitioners to carry out a public health role, and some of the factors which act as aids and hindrances in the translation of theory into public health practice once they are qualified. In looking at effectiveness in practice, practice examples were reviewed in relation to the health benefit cycle. They generally conformed to the early stages but were not precise. In curriculum documents, learning objectives of relevance to public health were few. A commentary has been presented on the UKCC standards for community specialist practice which highlights questions to be addressed in relation to public health. Study findings indicate that newly qualified practitioners might experience difficulty in achieving relevant standards.

The study team looked at how current and future specialist roles might develop and considered students', course teams' and service managers' perceptions of current and future public health roles. The research team also considered the implications of potential developments in post-registration education on public health for pre-registration education and practice, and discussed the implications of the Peach Commission's recently published report. Prior experience in community settings appeared to be important in further learning about public health work. Incorporating interdisciplinary learning within curricula would provide a strong base for collaborative working. Developments in practice based assessment and spanning the theory-practice gap may be transferable to deal with issues raised in relation to community specialist courses.

CHAPTER ONE

1. INTRODUCTION

After what seems like years of neglect, public health is once more central to health policy. What is more, public health is being defined in terms which bring together not only the view of public health as centred on health needs assessment at the district level through epidemiology, or, sometimes, the surveillance, prevention and control of infection, but also the view espoused by the WHO in its Alma Ata declaration (WHO 1978), that health is the product of social, psychological and environmental as well as physical factors, and for example, significantly affected by poverty. In its recent publications (DOH 1997; DOH 1998a; DOH 1999), the new government has begun to explore the potential of engaging local authorities, voluntary agencies and even the public themselves in developing plans for health improvement. In this more inclusive view of public health, nurses have a significant role to play.

The potential of nurses to contribute to the promotion and maintenance of the health of the public has been recognised in the past - for example in the SNMAC report 'Making it happen' (SNMAC 1995) - but has been almost marginal in a context which looked mainly at health as the absence of disease. Public health work in nursing can include at one extreme commissioning health services, or at the other intervening to promote health - for example by providing an immunisation programme for a particular population. Most often it is viewed as providing care through collaboration with a range of groups (health professionals, local authorities and voluntary agencies as well as local people), to "protect and promote health and well-being, prolong life and prevent ill-health in local communities, groups and populations"(SNMAC, 1995, p5).

A majority of the contact (around 95%) between the public and the NHS takes place in community settings - mostly in primary care. The community is where most of the population live, and seek to manage their health . However, despite the inter-relationships between notions of primary care espoused by the World Health Organisation and issues of public health, little has been done to explore how these operate on the ground. The context in which they relate is rapidly changing. Primary Care Groups have been brought together with responsibility, in the first instance with Health Authorities, to produce a viable Health Improvement Plan (HImP) for the populations they serve. Though PCGs include a variety of disciplines, it is often in practice General Practitioners and community nurses, especially health visitors, who are charged with finding ways of identifying and meeting health needs for the populations with which they work.

In 1995, Bhopal advocated a much stronger public health role for General Practitioners, but also identified some of the barriers to this in existing patterns of work, not least their tendency to focus on disease management (Bhopal 1995). The burden of public health work therefore rests largely with community nurses,

particularly health visitors, a reality recognised in the 1999 white paper on public health, *Saving Lives: Our Healthier Nation* (DOH 1999). In 1979, a working group of the Council for the Education and Training of Health Visitors suggested that health visiting revolved around four key public health principles - the search for health needs, stimulation of awareness of health needs, facilitation of health enhancing activities, and influence on policies affecting health. Revisited ten years later, these principles were found to hold good (Twinn and Cowley 1992). These principles were incorporated in modified form within the UKCC's 1994 '*Standards for education and practice following registration*' as they relate to all community specialist practitioners (UKCC 1994). The study described in this report examines how far programmes of education successfully prepare specialist community nursing practitioners to carry out a public health role, and some of the factors which help or hinder the translation of theory into public health practice once they are qualified.

This study was commissioned in order to inform the ENB and UKCC in their thinking about the preparation of community specialist practitioners to undertake public health roles. Preparation for such roles has become increasingly important with recent policy shifts, whilst educational programmes have been undergoing significant change. This study was in part directed at examining how far students emerging from the new programmes were prepared to carry out the new 'public health' agendas. To do this, the study was designed in three distinct parts. Firstly, educators were asked about the courses they provided - what they delivered, and their views on public health work in practice, now and in the future. Secondly, managers in practice (in Trusts and Health Authorities) were asked about current public health work and their perceptions of the future of this area of work. Finally, four sites were chosen at which snap shots of the educational process could be obtained through interviews with those commissioning, delivering, receiving and using education for public health work in community specialist practice. Each site constituted a case study.

This chapter sets out some of the background to the study. The question 'what is public health' is first addressed briefly. Models of public health in common use and public health policy are outlined. The nursing contribution to public health is discussed, leading into some of the debates within education about the preparation of community specialist practitioners.

1.1. Public Health

What is public health? In essence it is the promotion and maintenance of health within a given population. It contextualises health care by placing the individual within a community or an organisation - for example a workplace or a school, rather than taking a view of each person alone. Health is defined in three main ways. The first is often described as the 'medical' model of health - that health is the absence of disease. It is described in this way because health is seen as the absence of pathogens and disease processes. Medical interventions are frequently geared to avoiding or destroying pathogens or arresting disease processes. The second view can be described as the 'functional' model of health - often used in relation to people with disabilities, or older people. Difficulties arise with this model in a society where the boundaries of everyday function and the technological supports available are changing rapidly, and where activists have strongly put the case for a social model of

disability which makes clear that it is the product of society's inability to adapt to respond to impairments, demonstrated in function. An extension of this idea is the notion of 'social health' - an ability to fulfil social roles. This is in many ways the obverse of Parsons idea of the sick role (Parsons 1960), in which being 'ill' confers exemption, for a period, from social roles. The third view suggests that how people feel about themselves is more important than impairment or a disease process. The World Health Organisation, in 1948 brought together these ideas when they stated that health was 'a state of complete physical, mental and social well being and not merely the absence of disease' (WHO 1978). Whilst this has been criticised as utopian, it has the merit of integrating the three most common conceptualisations. Health is thus not one, but a number of ideas, which operate in different peoples minds at different times in considering how the health of the public may be promoted and maintained.

There are two dominant models of public health. One, most clearly seen in the 'Health of the Nation' document (HMSO 1992), is built around the medical model, and looks in the main at individuals' behaviour, focusing on the responsibility of each individual to contribute to preventing disease and improving health targets. The second model is constructed around community development ideas such as empowerment, and utilises a salutogenic model of health (Antonovsky 1996), in which the key to a healthy population is that it has the resources for health.

One approach which has sought to use both models was developed in the early 1990's - the 'new' public health (Ashton 1988). This draws on the WHO's definition of health, acknowledging that health is a product of many factors, and that work to promote and maintain health requires a balance between individually focused work and work at the level of society. Ashton was involved in the development of the Healthy Cities Initiative which encouraged local authorities across Europe to work with health authorities and local people to set targets for a healthier city. Steve Watkins was another pioneer of this new way of looking at public health. Against the grain of policy at the time, he facilitated the establishment of an integrated public health service in Stockport, which offered community based health development work as well as large-scale intervention programmes.

Promoting and maintaining the health of the public is now a central plank of the government's policies. The appointment of a Minister for Public Health in 1997 confirmed that this was the case. The publication in quick succession of several green and white papers reinforced this, and emphasised the importance both of communities and of primary health care as a setting for public health work. The White Paper (*New NHS: Modern Dependable*) shifted commissioning towards a health oriented model and more firmly into primary health care. The Green Paper (*Our Healthier Nation*) highlighted the importance of community development approaches and of looking at environments (school, work and community) as well as the management of disease processes. Late in 1998, the Acheson Report on Inequalities in Health (Acheson 1998) and the publication by the Home Office of a green paper called *Supporting Families* (Home Office 1998) gave further momentum to the shift to a psychosocial model of health. Finally, in summer 1999, the public health white paper set out in detail the ways in which the government hoped to improve the health of the people of England. Firstly, people would be facilitated to improve their own health. Secondly,

communities would be encouraged to tackle factors leading to poor health - for example poor housing or polluted environments. Thirdly the Government would address overall policy, seeking to create a 'joined-up' approach. Primary Care Groups would be key players in achieving this programme, and community nurses would have a central role in this.

1.2. The Nursing Contribution to Public Health

The contribution of nurses, midwives and health visitors to the process of creating and promoting the health and well-being of the populations they serve has been viewed in a variety of ways. On one dimension, the issue has been about whether a contribution can be made at all. On another dimension, debate has centred around the level of contribution made by different practitioners. Debate about whether nurses can indeed contribute to 'public health' work reflects a rather narrow perception of public health as largely about health needs assessment through epidemiology, or, sometimes, the surveillance, prevention and control of infection. Since on the whole, nurses have had little contribution to the former and a limited involvement in the latter, proponents of this model have seen nurses as marginal players. However, the SNMAC report, '*Making it happen*', published in 1995, reaffirmed the 'significant contribution that the nursing, midwifery and health visiting professions are making to public health', and called for further development of the professions' contribution to the public health. They defined public health in nursing midwifery and health visiting practice as:

> "about commissioning health services and providing professional care through organised collaboration in the NHS and society, to protect and promote health and well-being, prolong life and prevent ill-health in local communities, groups and populations"(p5)

The educational preparation of nurses to undertake roles in public health is of central importance to this.

Discussion about the *level* of contribution to be made by nurses has revolved around distinguishing some of the differences between nurses who provide immunisations, screen well people, or contribute to a cardiac rehabilitation course, those who work in community development and those who are involved in commissioning services. The distinction arrived at in one discussion is threefold: public health in nursing, nurses working in public health, and public health specialist nurses. Public health in nursing reflects the contributions made by nurses working with individual patients in all settings towards the overall public health. Nurses working in public health reflects the work of nurses where public health goals and skills are central. Public health specialist nurses, within that group, would reflect those with further developed public health knowledge and skills.

Changes in the delivery of healthcare make it increasingly desirable that more nurses move into a public health role, and that some are adequately prepared as public health specialists. It is therefore of considerable importance to determine how effectively specialist practitioner programmes prepare key groups of community nurses (district nurses, general practice nurses and public health nurses / health visitors) for these

new roles, what roles managers, practitioners and commissioners envisage developing, and to examine the implications of the changes occurring in post-registration education for pre-registration preparation.

This project is therefore intended to focus on the outcomes for public health practice of district nursing, general practice nursing and public health nursing / health visiting programmes. The health benefit cycle (SNMAC, 6.4) has been used to describe the public health process in strategic management and contracting, and to evaluate systems for delivering health outcomes. It identifies the skills and knowledge base required for a public health driven NHS. Such skills include leadership, understanding the assessment of health care needs within a population, understanding the processes of commissioning for health services, and developing communication and negotiation skills. A central component is partnership, with the ability to collaborate forming an essential prerequisite to effective public health work. Courses preparing nurses for a public health role should therefore address the acquisition of such skills and practitioners' ability to utilise them *within the realities of practice*.

1.3. The Educational Preparation of the Specialist Community Nurse

In 1994 the UKCC issued their standards for education and practice following registration. These standards were a result of the deliberations of the Post Registration Education and Practice Project (PREPP) which had identified:

- The need for a coherent and comprehensive framework for education beyond registration
- A framework which establishes minimum common standards
- The need to improve the quality of continuing education
- The need to support and enhance opportunities for those on the register to maintain and develop their professional knowledge

The need for on going professional, development was identified in the PREPP document thus

"Whilst pre-registration education provides practitioners with the knowledge, skills and attitudes to give safe and effective care, professional practice alone following registration is not enough to meet additional specialist needs. Specialist health care and specialist patient/client requirements call for additional education for safe and effective practice. There is therefore a need for some practitioners to be able to exercise higher levels of judgement and discretion in clinical care to function as specialist practitioners." (UKCC, 1994)

The UKCC now defines a specialist nursing practitioner as someone:

".....able to demonstrate higher levels of clinical decision making. Able to monitor and improve standards of care through supervision of practice, clinical audit, the provision of skilled professional leadership and through the development of practice through research, teaching and the support of professional colleagues."

In order to qualify as a specialist practitioner the nurse will be required to undertake a programme of study at first degree level, the minimum length of time being an academic year i.e. 32 weeks full-time (or equivalent part-time) and to consist of 50% theory and 50% practice. In relation to specialist community practice Council identified eight specific areas. These are as follows:

- General Practice Nursing
- Community Mental Health Nursing
- Community Learning Disabilities Nursing
- Community Children's Nursing
- Public Health Nursing/Health Visiting
- Occupational Health Nursing
- Community Nursing in the Home/District Nursing
- School Nursing

Programmes are required to consist of a common core preparation and specific modules. The core modules should form no less than one third and no more than two thirds of the total programme. Programmes of specialist education concentrate on four broad areas:

- Clinical practice
- Care and programme management
- Clinical practice leadership
- Clinical practice development

The document identifies both common core learning outcomes for these four areas and specific learning outcomes applied to the area of practice for two i.e. clinical nursing practice and care and programme management. Whilst broad learning outcomes are articulated there is no guidance given about how these outcomes should be assessed.

The first programmes became available from 1995 with the expectancy that educational institutions which offered community nurse education would all have changed to these new programmes by 1998.

Prior to the introduction of the new standards the educational preparation of nurses working in the different fields of community practice had been varied ranging from a one year statutory course for which the qualification was registered (health visiting) through varied lengths of mandatory (district nursing) and non-mandatory courses (school nursing, occupational health nursing) for which the award was recorded.

The UKCC's aim to apply a single framework for post registration courses created a situation where there has, for some disciplines, been a marked increase in the length of the course, for example General Practice Nursing whilst for others - in particular Health Visiting - they have been reduced from the 51 week requirement laid down in the Health Visitor training rules (Statutory Instrument No109). Until such time as legislation is amended these regulations are still extant . The new Specialist Practitioner programme then for health visitors is deemed to be a *"modified course"* approved by the Council for the purposes of health visitor education.

PREPP makes a clear statement about practising within a speciality and practising at a specialist level which is about higher levels of discretion and decision making though this clearly causes a great deal of confusion for many. In spite of attempts to clarify its meaning it is still often interpreted as referring to an area of practice rather than this higher level of practice. It is also fair to say that this confusion has been accentuated by its operationalisation in the community with the clear identification of the eight discrete areas of community nursing practice which describe existing roles.

Furthermore it is the speciality which has caused concern to many lecturers in health visiting (Johnson 1999). The amount of time for the theoretical study in the educational institution is variable but can translate into 60 hours teaching. Where health visitor students, who can enter training from all areas of the Register are moving into a new area of practice, based on a new body of knowledge, questions have been asked about the limited time available. No University can hope to prepare their students to fulfil all of the dynamic and diverse roles that, once qualified, they may undertake. It is perhaps more important that they are equipped with a broad range of skills and strategies on which to draw. Nevertheless concern has been expressed as to whether there is sufficient grounding in some of the basics and a general feeling that there has been an overall diminution in the public health perspective in programmes leading to registration on part 11 of the Register. This does seem to be a paradox when the new title identified by PREPP for this practitioner is *"Public health nurse: Health visiting"* It also begs the question as to whether health visiting is synonymous with public health nursing .

In addition questions have been asked - *"how can such nurses be called specialist so early in their professional careers and are all current graduates of community programmes specialist practitioners?"* (UKCC 1997) A course alone does not turn a practitioner into a specialist practitioner and registered practitioners may need time to grow into this new level.

1.4. Community Specialist Practice

Specialist practice is 'the exercising of higher levels of judgement, discretion and decision making in clinical care' (UKCC 1994). Although in principle this level of practice may be found in any arena of nursing practice, it has been most commonly described in community settings, for which specific requirements have been laid down. All community nurses should achieve a set of 27 core outcomes, grouped under the headings 'clinical nursing practice', 'care and programme management', 'clinical practice leadership' and 'clinical practice development' (see Appendix 1). In addition, each of the eight types of community specialist practitioner should achieve a specific set of outcomes for that group.

The outcomes described for community specialist practitioners are not grouped according to area of practice. It is therefore not clear precisely which outcomes may be considered as relating to public health work, and this becomes a matter of interpretation. Given the key importance of such outcomes in course design and validation, the study team set out to examine the outcomes as a whole, and provide an analytical commentary on those which appeared to have relevance to public health

work. In the sections which follow, comments are intercalated with outcomes, the latter being presented in boxes, numbered as in the original.

1.4.1. Clinical Nursing Practice

13.1 assess health and health related needs of patients and clients, their families and other carers and identify and initiate appropriate steps for effective care for individuals, groups and communities.

Practitioners should be using a systematic approach to health needs assessment and should know about and use a variety of tools in this.

13.2 plan, provide and evaluate skilled nursing care in differing environments and with varied resources. Specialist community nurses must be able to adapt to working in peoples homes and also small institutions, health centres, surgeries and places of work.

This raises questions about the nature of 'skilled public health nursing'. How do practitioners assess the quality of their public health work? The environment in which nurses practice will also affect the direction and model of public health which they adopt.

13.3 support informal carers in a partnership for the giving of care. The majority of care in the community is given by informal carers. They need guidance, support and resources to carry out tasks so that there is continuity of care for the patient.
13.4 assess and manage care needs in a range of setting. These are complex activities which call for informed judgement to distinguish between health and social needs recognising that the distinction is often a fine, but critical one.

Ideas of partnership are important in public health work, though this standard discusses it in relation to carers only. The judgement of health and social needs is closely related to the judgement of risk in particular settings and circumstances. Public health work is likely to be about building up resources to cope with risk rather than actively intervening.

13.5 provide counselling and psychological support for individuals and their carers
13.6 facilitate learning in relation to identified health needs for patients, clients and their carers

These standards appear to focus on individuals rather than groups or communities: Public health work does take place at an individual level where it is embedded within a collective approach at the level of practice, institution or community.

13.7 prescribe from a nursing formulary, where the legislation permits.

Whilst public health work is less about intervention than prevention and promotion, there are some areas where the boundary is blurred. For example, in many innovative attempts to work with homeless people to promote and maintain their health, the availability of relevant medication, whether by prescription or through protocols, is an important element.

13.8 act independently within a multi-disciplinary/multi-agency context

Standard 13.8 relates to the context in which public health work is done. In particular it promotes the value of multi-agency and multi-disciplinary networks - not just primary health care teams but also social services departments, housing and the voluntary sector for example - essential elements of an integrated model of public health.

13.9 support and empower patients, clients and their carers to influence and use available services, information and skills to the full and to participate in decisions concerning their care.

This standard emphasises the importance of supporting and empowering patients clients and carers to act for themselves within health care systems - a central component of more socially oriented models of public health.

1.4.2. Care and Programme Management

13.10 advise on the range of services available to assist with care. The services may be at local, regional or national levels. Knowledge of these services will need to be kept up to date and advice given to people on how to access and use them.

In the context of public health, care must be interpreted as including preventive and health promoting activity. This standard then highlights the importance of practitioners being aware of the range of agencies which may be of relevance to the health of the populations they serve.

13.11 recognise ethical and legal issues which have implications for nursing practice and take appropriate action.

In relation to public health work, the main ethical and legal issues confronting practitioners are likely to lie in the allocation of scarce resource, the evidence base available on which to base decisions, limitations of capacity (for example shortages of appropriately trained staff), and issues in relation to specific action taken or planned.

13.12 identify the social, political and economic factors which influence patient/client care and impact on health.

As the Acheson Report (1998) has clearly set out, social, political and economic factors are all of considerable importance in the health status of individuals and communities, and in identifying ways in which their health may most effectively be promoted and maintained.

13.13 stimulate an awareness of health and care needs at both individual and structural levels. Activities will include work with individuals, families, groups and communities and will relate to those who are well, ill, dying, handicapped or disabled. Thos who are able should be assisted to recognise their own health needs in order to decide on action appropriate to their own life-style. Those who are not able will require skilled and sensitive help.

Standard 13.13 focuses on two key principles of public health work - stimulating awareness of health needs with and the facilitation of health enhancing activities, mirroring the CETHV's (1977) formulation of the principles of health visiting.

13.14 identify and select from a range of health and social agencies, those which will assist and improve the care of individuals, groups and communities.

Just as in standard 13.8, this standard relates to the context in which public health work is done and the need to know and use the networks in building up and maintaining the health of the public.

13.15 search out and identify evolving health care needs and situations hazardous to health and take appropriate action. This is a continuous activity and involves being pro-active, it must not be dependant on waiting for people to request care.

Building on the ideas set out in standard 13.13, this standard indicates the importance both of a *proactive* approach to searching out health care needs - not passive data collection - and the need to recognise that health care needs are *evolving* from day to day - for example with the needs of new groups of refugees, or changing disease experience.

13.16 initiate and contribute to strategies designed to promote and improve health and prevent disease in individuals, groups and communities.

Once again, this standard picks up a key principle of public health work, in effect taking the notion of influencing policy affecting health forward. The balance between initiating and contributing to strategies may reflect how far a practitioner is functioning as a nurse working in public health or as a public health specialist.

13.18 empower people to take appropriate action to influence health policies. Individuals, families and groups must have a say in how they live their lives and must know about the services they need to help them do so.

This standard seeks evidence of a practitioner empowering people vis a vis policy - to achieve 'healthy public policy' in relation to individuals, groups and communities, at local, regional and national levels

13.18 provide accurate and rigorously collated health data to employing authorities and purchasers through health profiles in order to inform health policies and the provision of health care.

The evidence required to meet this standard - evidence of accurate and rigorously collected data and of passing this on to employers/purchasers (commissioners) through health profiles should be relatively concrete. However, it also highlights the way in which effective public health work can be dependent upon the information systems available to practitioners.

1.4.3. Clinical Practice Leadership

13.19 act as a source of expert advice in clinical nursing practice to the primary health care team and others.

This standard requires a practitioner to produce evidence of team work, whether with immediate colleagues or a wider group. This is a central component of descriptions of the nursing contribution to the public health agenda.

13.20 lead and clinically direct the professional team to ensure the implementation and monitoring of quality assured standards of care by effective and efficient management of finite resources.

Public health work must incorporate attention to effectiveness, since the resource available is always finite. This standard sets out the requirement for the specialist practitioner to be able to utilise limited resource wisely in seeking to achieve healthier populations.

13.21 identify individual potential in registered nurses and specialist practitioners through effective appraisal system. As a clinical expert advise on educational opportunities that will facilitate development and support their specialist knowledge and skills to ensure they develop their clinical practice *and*
13.22 ensure effective learning experiences and opportunity to achieve learning outcomes for students through preceptorship, mentorship, counselling, clinical supervision and provision of an educational environment.

Community specialist practitioners need to be able to facilitate colleagues and students in learning about public health as much as about other parts of their work. These standards suggest that practitioners should be prepared to provide appropriate learning opportunities for this as for many other areas of practice.

13.23 initiate and lead practice developments to enhance the nursing contribution and quality of care.

In examining this standard, it is important to reflect on how far practitioners are changing practice towards public health work and to ask - Are they trying? What stops them? What helps them?

13.24 identify, apply and disseminate research findings relating to specialist nursing practice.

Practice based on research evidence is a core philosophy within the 'new NHS', in public health work as in other areas. However, achievement of this standard is likely to be restricted because the nature and scope of the available research evidence is currently limited in relation to specialist nursing practice in the area of public health.

13.25 undertake audit review and appropriate quality assurance activities.

13.27 explore and implement strategies for staff appraisal , quality assurance and quality audit. Determine criteria against which they should be judged, how success might be measured and who should measure success.

As stated earlier, it is as important to ensure adequate attention to the quality of interventions in a public health context as in any other, asking whether health needs are being correctly identified and whether they are being appropriately and effectively met to create the maximum impact on peoples health for the available resource.

13.26 create an environment in which clinical practice development is fostered, evaluated and disseminated.

Specialist practitioners need to be creative, developing practice rather than delivering established packages of care. This is particularly the case in public health work, where the complex nature of the health needs of any community are likely to require creative approaches to their solution.

This study seeks to determine how far community specialist practitioners are being prepared to meet these standards and, in particular, how far they are able to achieve public health agendas in practice. It will provide outputs in the following areas:

- Information about public health-related learning outcomes for community specialist practitioner programmes in England.
- An overview of measures of effectiveness for public health-related outcomes for community specialist practitioners in England.
- Preliminary quality indicators for public health work by community specialist practitioners.

- Indications of the likely impact of changes occurring in post-registration education for pre-registration preparation.

1.5. Summary

This chapter has provided an overview of the background to this study. Public health work was defined as the promotion and maintenance of health within a given population. It was noted that there are two dominant models of public health. One is constructed around the medical model, and looks in the main at individuals' behaviour, focusing on the responsibility of each individual to contribute to preventing disease and improving health targets. The second centres around community development ideas such as empowerment, and uses a salutogenic model of health in which the key to a healthy population is that it has the resources for health. Both are of relevance in current policy.

It was noted that promoting and maintaining the health of the public is now central to government policy. The publication of a series of green and white papers has reinforced this, and emphasised the importance both of communities and of primary health care as a setting for public health work. The contribution of nurses, midwives and health visitors to the process of creating and promoting the health and well-being of the populations they serve has been viewed in a variety of ways. At one level the question has been whether a contribution can be made at all. At another, debate has centred around the level of contribution made by different practitioners. The SNMAC report (1995) reaffirmed the 'significant contribution that the nursing, midwifery and health visiting professions are making to public health', and called for further development of the professions' contribution to the public health. The public health White Paper has confirmed the importance of nurses' involvement. It was therefore concluded that the educational preparation of community nurses to undertake roles in public health is of central importance for the future.

Finally, the educational and regulatory framework was examined. It was noted that the UKCC has defined eight types of community specialist practitioner and set out new standards for their preparation. In order to qualify as a specialist practitioner each nurse is required to undertake a programme of study at first degree level, the minimum length of time being an academic year, consisting of 50% theory and 50% practice. Programmes consist of a common core preparation and specific modules. Whilst public health is not explicit within the standards, a number of outcomes were described which appear relevant in relation to the promotion and maintenance of the health of the public.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Introduction

This chapter seeks to provide an overview of literature which contributes to an understanding of public health nursing education and practice. It begins by considering the broad conceptual framework adopted in this study. It then addresses three areas. Firstly, literature addressing the nature of public health work in nursing is examined, and set in the context of recent policy developments. Within this the potential public health contribution of different community specialist practitioners is reviewed. Secondly, papers addressing effectiveness in relation to public health and health promotion are considered. Thirdly, literature relating to the educational preparation of practitioners for public health roles is explored, including recent work looking at interdisciplinary approaches to preparation. Links are made to the initial preparation of first level nurses.

2.2. The Conceptual Framework Of This Study

In the previous chapter, public health work was defined as work to promote and maintain the health of a given population or community. Two dominant models of public health (medical and social) were outlined, and it was suggested that both are of relevance to current policy. This study is framed within an understanding of the health of the public as multi-faceted (biological, social, psychological and emotional) and capable of being influenced at individual, family/organisational, community or environmental levels (see for example Kelly and colleagues, 1993). The agents of such influence may be within the context or beyond, but are likely to include both lay people (for example parents) and professionals (for example nurses).

For both groups, the process by which they seek to influence health is likely to be informed by their beliefs about and understanding of the mechanisms by which such influence can be exerted, *and* their experience of the outcomes of particular actions - see for example Prochaska and DiClemente (1982), Mayall (1986), Cornwell (1984), Pearson (1991). Whilst traditional approaches to knowledge emphasised the importance of formal knowledge, more recent understandings have begun to re-evaluate the importance of experiential knowledge, and to examine ways in which the two inform each other, leading for example to the work of Benner (1984), Schon (1991) and Eraut (1994). For professionals, their beliefs and knowledge about the process of influencing health are likely to be significantly derived from their educational preparation (see for example Snowden 1997), whilst their experience of the outcomes of particular actions in different contexts may be tempered by their formal knowledge of the effectiveness of these, as suggested for instance by Kim (1999).

Within this chapter, the literature is therefore explored to develop an understanding of previous work on:

- the context (both policy and environment) in which public health is influenced and maintained,
- the nature and scope of the influence of community nursing, and
- current evidence about the effectiveness of actions to promote and maintain health.

2.3. The Context: Recent Policy Developments

In the time period covered by this study, the public health policy context has shifted considerably. The study began in 1997, having been planned during 1996. As it draws to a close, we are approaching the second millennium. In that time there has been a change of government and a shift towards the acknowledgement of poverty as a factor in the inequalities of health experience. In 1996, and through into early 1998, the key policy document setting out the way in which the health of the public might be promoted and maintained was *The Health of the Nation* (1992). For the first time in the UK this set out 'health' targets to be attained, focusing on five major areas of disease experience and health care expenditure. However, it took what was essentially a medical perspective in its focus on disease, and sought to influence individual behaviour - for example reduce smoking or the intake of fat in people's diet, rather than considering social or environmental factors which might influence health experience. In the summer of 1996, the Conservative government was also drawing together the strands of a new approach to primary health care which had originated almost a year before. Much of this work appeared to assume that 'primary health care' was congruent with 'primary medical care' or general practice. However, amongst the 'characteristics of good primary care' which they listed, they said that it should 'address the health needs of both individual patients and the general population' (NHSE 1996). In December 1996 this was transformed into a white paper - *Primary Care: Delivering the Future*. This highlighted the need for greater patient and carer involvement in health care 'to help people make informed decisions about their own health care' (p27), and floated the idea of locality purchasing and commissioning pilots, bringing together groups of practices to work with Health Authorities to 'improve the planning and purchasing of services and the use of resources for local people' (p50). Before this progressed very far the election of 1997 intervened. In the summer of 1997, a lot of activity ensued. The Chief Medical Officer was asked to set in train a review of public health work 'with a view to ensuring that there [was] a robust public health function to deliver the Government's public health strategy and agenda' (Chief Medical Officer 1998). The interim report of this project was published in February 1998, and *inter alia* stated that there was 'a need to develop, for public health specialists from a variety of professional backgrounds, career pathways, accreditation systems and equal opportunities, for all to contribute' (p1) - to achieving the new health care agenda. It also stated that ways were needed 'of ensuring that local action [could] be sustained over time eg through community development' (p2). Work also began in the summer of 1997 on an NHS White Paper - *The New NHS, Modern, Dependable*, which would be published in late 1997 and set out proposals for Primary Care Groups, responsible for local 'Health Improvement Programmes'. At the same time work started on the Green Paper *Our Healthier Nation* which was published in early 1998. This for the first time took on board much of the thinking which had developed in discussions within the World Health Organisation (WHO 1978) and amongst health promoters in Ottawa (International Conference on Health Promotion 1986). It was proposed that action should be built on

a knowledge of population health needs, but would also emphasise collective and collaborative action - for example in the development of Healthy Living Centres to serve local communities. People were recognised as members of groups and communities - for example in schools and workplaces, not just as individuals.

In November 1998 another important government paper was published, entitled *Supporting Families* (Home Office 1998). It set out the need to act preventively with families in order to avoid family disturbance and breakdown, and its behavioural and social consequences. It proposed a strengthened role for health visitors, though paying less attention to the potential work of school nurses. It placed the family at the centre of the health and well-being of the community in its broadest sense. In its Home Office origin it also appeared to signal an increasing awareness that health is influenced by many different agencies, or perhaps that health is relevant in considering crime, and that agencies must begin to co-ordinate their thinking nationally and locally to impact on the day to day lives of people in communities. In December 1998, the DfEE published another document with a similar focus setting out a programme to provide sustained intervention with families and children under five in areas which were not the most deprived, but in which there was potential for change (DfEE 1999). This was the launch of *Sure Start*, A little later, Sir Donald Acheson's Independent Report on Inequalities in Health was published, setting out clearly the case for action across society and particularly in economic terms and with young families to redress the balance (Acheson 1998).

After a long gestation period, in July 1999, two further documents were published. The White Paper on public health, sequel to *Our Healthier Nation*, was published, now known as *Saving Lives - Our Healthier Nation.* It set targets in four key areas - cancer, coronary heart disease and stroke, accidents and mental illness and acknowledged that 'the social, economic and environmental factors tending towards poor health are potent' (p3). Three levels of activity were suggested to promote public health. Firstly, people could be facilitated to improve their own health. Secondly, communities could tackle factors leading to poor health - for example poor housing or polluted environments. Thirdly the Government would address overall policy. Smoking was directly targeted with its own green paper (DOH 1998b). In addition, the Government proposed to tackle wider inequalities through initiatives on for example, education, welfare-to-work, housing and transport. Other significant health issues such as sexual health, drug and alcohol use, food hygiene and communicable diseases were not ignored, though accorded rather less importance. In Chapter 11, which addressed preparing the workforce necessary to deliver this agenda, considerable attention was paid to nursing. In particular, health visitors and school nurses were acknowledged as public health practitioners, focused in the first instance around families and communities, and in the second around children and young people, parents and school communities. The panel below shows the key outcomes listed for the new health visiting role:

- Parents will receive improved support including parenting education, health advice and information
- Individuals and families will be able to have a tailored health plan agreed in partnership with the health visitor to address their parenting and health needs.

- The health needs of families and communities will be met by a team led by a health visitor including nurses, nursery nurses and community workers.
- Health visitors will initiate and develop programmes for outreach, based on the experience of organisations such as Homestart, New Pin and 'community mothers', where local parents use their experience to support others.
- Neighbourhoods or special groups such as homeless people within a practice or primary care group will have their health needs identified by health visitors, who ill lead public health practice and agree local health plans.
- Local communities will be helped to identify and address their own health needs, for example accident prevention for older people. [11.17, page 133, *Saving Lives - Our Healthier Nation*]

Published second, but of equal relevance to the present work, was the new strategy for nursing, midwifery and health visiting, *Making a Difference* (DOH 1999). In this, once again, the message was re-iterated that 'Nurses, midwives and health visitors are crucial to the Government's plans to modernise the NHS and to improve the public's health' (p4). The document set out the changing nature of health and social care, and the need for nursing, midwifery and health visiting to be strengthened by improved recruitment, strengthened education and training, enhanced career structures and the development of new ways of working. Strongly signposted amongst the last group was a 'modernised' role for health visitors, working in teams to 'develop and deliver health improvement programmes and action set out in *Saving Lives - Our Healthier Nation*' (p61), and a more developed role for school nurses. A 'family centred public health role for health visitors' would involve them in:

- Delivering child health programmes and working with families to address their parenting and health needs.
- Running parenting groups and providing support to vulnerable families - for example through Sure Start.
- Working through Primary Care Groups to identify local health needs and agree plans.
- Working with local communities to help 'stimulate awareness of health needs' and 'facilitate health enhancing activities' (CETHV 1977).
- Providing health promotion programmes in key target areas.

The emphasis placed on nursing roles in public health work may reflect an increasing awareness that resources in this area remain finite, indeed that GPs, who might classically have acted as a key focus, are reducing in number. Although the number of unrestricted GPs in England and Wales increased by 12% between 1985 and 1997, the number of GP registrars (ie those entering training) decreased by 27% (more than a quarter) over the same period. However, it is also important to note that numbers of community nurses nearing retirement have increased.

As well as school nurses, infection control nurses and occupational health nurses were highlighted as 'public health practitioners' (p62-3). Practice nurses were noted as having an important and unique role in surgery based health promotion and disease prevention as well as treatment, and involvement in these areas across all generations. However, though district nursing roles were valued as 'central to the capacity of individuals to remain in their own homes, receiving appropriate packages of nursing

care and treatment through acute, chronic and terminal illness' (p63), in paragraph 10.17 reference is made to deficiencies in current provision (due to increased demand) highlighted by the Audit Commission (Audit Commission 1999), and the suggestion is made that the interface between district nursing and practice nursing should be reviewed.

2.4. The Nature of Public Health Work in Nursing

Precisely what public health work involves in nursing has long been a subject for debate. One of the most widely cited discussions of this topic is the report produced in 1995 by the Standing Nursing and Midwifery Advisory Committee, *Making It Happen* (SNMAC 1995). This report began by stating that:

> 'public health in nursing, midwifery and health visiting practice is about commissioning health services and providing professional care through organised collaboration in the NHS and society, to protect and promote health and well-being, prolong life and prevent ill-health in local communities, groups and populations'.

It went on to suggest that the contribution of nursing, midwifery and health visiting to public health was grounded in six concepts. Firstly, they would use *public health approaches*. The authors suggested that such approaches would typically include the identification of health needs and desired outcomes, agreement on the most effective action and evaluation. Secondly it would be built on a *knowledge of population health needs*. Third it would emphasise *collective and collaborative action*. Fourth, there would be recognition of *people as members of groups*, not just as individuals. Fifth they would be working to a *public health perspective* which picked up the social, organisational and policy aspects of health development. Finally, there would be a focus on *disease prevention and health promotion*, 'enabling people to increase control over and improve their health'. Caraher and McNab (1996) criticise the SNMAC report for being too individually orientated, with little emphasis on wider community determinants of health. This may to some extent reflect its origins within the Department of Health at a time when there was no acknowledgement of the impact of poverty on health. However, the examples given in subsequent chapters include a wide range of work contexts and approaches, all with some element of collectivity involved.

In discussions since the production of the SNMAC report, three types of nursing involvement in public health work have been described. Contributing to public health is part of the role of every nurse, midwife or health visitor. Public health nursing involves practitioners whose whole role, or a significant part of it, is committed to work with groups and communities to build up and enhance public health. Public health specialist posts are then effectively held by nurses who have advanced or higher level skills in public health work, possibly at Masters or Doctoral level, and seek to influence the health of populations through developing policy and taking action at a macro level. This division has some resonances with the models of community health practice presented by Chalmers and Kristjanson (1989), namely the 'public health' model, the 'community participation' model and the 'community

change' model, at least in so far as these demonstrate different levels of engagement with the community.

A search of CINAHL and MEDLINE covering the last decade for papers on public health/nursing/health promotion/community health revealed relatively few published papers addressing public health roles in nursing. Most appeared to be descriptive, even anecdotal, though there were some discussion papers, opinion pieces, and others which were research based.

Caraher and McNab (1996) looked at the future of public health nursing and criticised government reports such as *Health of the Nation* for not addressing the determinants of health, such as poverty or housing. Health promotion was also criticised for being too medically determined. Health visitors are seen as being restricted by the focus on general practice. Caraher and McNab suggested that the challenge for public health nursing was to break free from medical dominance and broaden the delivery of public health. Nurses should not only map patterns of disease in localities but also identify root causes and tackle them. They should seek to effect change in service delivery - not only in health arenas but also in sectors such as public transport or crime prevention. A number of issues arise. In looking at public health functions these should include the determinants of health within health needs assessment. In this case social and environmental conditions will need to be incorporated in assessment. Caraher and McNab question whether public health roles and functions should be disengaged from health and put back in the local authority or in the voluntary sector. Looking at existing services, they question whether public health nursing is separate from traditional health visiting and community nursing in a context of practice attachment, and suggests that nurses must learn to work with communities and not just practice populations.

Gilbert (1996) describes one way in which health visiting might adapt to take on a more explicitly public health role. In a personal account she describes the development of a post to work on an isolated housing estate in London. She campaigned about local health needs through lobbying and report writing, and suggests that the role developed around needs assessment and profiling, rather than community development work. Funding for the post was part of a regeneration bid which involved collective data analysis and a multi-agency approach. Her overall picture of the estate was built up by meeting people providing services and facilities on the estate. This generated networks and fostered relationships with tenants and workers. The intended outcomes of Gilbert's post for local people were firstly to give them a voice, in order to allow (sic) participation, and to enable them to sustain the health of their own community, secondly to influence services and make them more appropriate, improve access and improve the interface between services, and thirdly to facilitate residents to use health services more appropriately. Gilbert suggests a need to 'reconcile' the need for community development and the public health approach, which she appears to define in terms of needs assessment and profiling. She indicates that her underlying theoretical framework was built on the ideas of David Seedhouse (Seedhouse 1986), which envisages professionals and communities building on existing strengths and addressing needs together, taking a positive approach to health and seeking to remove barriers and obstacles to health. Despite Gilbert's uncertainties, it is not clear in practice how this approach differs from

community development work, which draws centrally on notions of community participation and empowerment (WHO 1978).

Watkins and Watson (1997) in another descriptive paper outline the development and operation of two public health projects in Stockport, which they locate within the wider context of public health nursing. In an earlier descriptive paper, Wearne (1992) discusses the functions of a public health nurse (originally a health visitor) based in a practice in Cheshire. This post was set up to identify local health needs, and to act as a facilitator within the community to help in the expression of local health needs by residents and a facilitator within the primary health care team to determine more effective ways to meet needs. The post-holder was to compile, analyse, interpret and present information in order to devise a comprehensive profile and provide a basis for purchasing, particularly to increase locally sensitive purchasing. In addition she was to establish shared goals and joint working strategies with the primary health care team and other local colleagues. Wearne concludes that this post enabled closer communication between GPs and community nurses, but warns that a public health nurse of this sort in every practice would not be cheap. She suggests that the public health role should be the joint responsibility of all primary health care team members. She highlights the need for training for all team members in data management and epidemiology, and the requirement for appropriate IT and suitable databases, whilst acknowledging that nurses are a good source of qualitative data about community health needs. In the development of this post, the local health forum was of key importance in increasing the role of local people in health. Wearne suggests that the lead public health role within a primary health care team could be adopted by the health visitors within a group, but notes that the facilitation of a public health role needs to be strategic.

The views of 130 practitioners about public health roles in nursing were explored in a Delphi survey, carried out in Oxfordshire and neighbouring areas by Lomax and Wright (1997). They found that for health care practitioners who are not specialists, the public health role was not clearly defined. However, there was general agreement about the health needs which typified local populations and about which professions should have the lead responsibility. Respondents indicated that public health activity was neither strategic nor systematic, and was characterised by numerous small scale initiatives. In addition, public health initiatives were not consolidated, there was little evaluation, and not much dissemination. Most health care professionals felt that they had little time for consolidation routinely. In addition, respondents complained of poor IT systems and skills, and suggested that investment was needed in structures, systems and training. Practitioners required new skills in information gathering, analysis and dissemination. Lomax and Wright suggested, building on their respondents' views, that the way forward would lie firstly in developing team-based rather than single profession approaches, implying a need for multi-disciplinary patterns of education. They also indicated the need to ensure that public health in primary health care had a more prominent place on health authority agendas. They highlighted the need to make better use of the public health skills and knowledge already in primary health care teams (largely in nursing) to co-ordinate and link all agencies on the broader public health picture. They suggested that public health departments could co-ordinate this work. Pre-figuring the idea of Primary Care Groups, they suggested that localities could be used as natural groupings to bring

together primary health care teams, public health and health authorities. In addition they recommended that better use should be made of the practice development planning process. Mechanisms should be established between health authorities, public health departments and primary health care teams to access and exchange relevant information to inform strategy. Looking at training, they recommended that shared training should be developed between public health and primary care to develop key skills in the area, and that better use should be made of training funds to promote public health skills development in primary care. Most respondents had not received any specific training in public health related areas since qualifying. Help with research appreciation, critical appraisal and epidemiology were most commonly highlighted. Respondents also suggested that skills and resources should be shared between health authorities and primary health care, building bridges between these levels of work.

Other countries have varied models of public health work and its links to nursing practice. In Canada the public health agenda has been shifting, with moves towards a socio-environmental view of health (Labonte1997). Reutter and Ford (1996) looked at 28 Canadian nurses' views of public health work, and highlighted four main themes in respondents' feelings towards it. They described public health work as enjoyable, demanding, not well understood, but valuable and worthwhile. Public health roles were seen as enjoyable when nurses were working in partnership with people. They identified as enjoyable operating as a 'generalist' working with a wide variety of people in different settings. They also enjoyed their perceived autonomy and independence. Aspects which were seen as demanding related to particular client groups and shortage of time. Clients with mental illness and high risk families were identified as especially demanding. However, the greatest stressor was perceived as lack of time. Public health work was perceived as not well understood. Respondents suggested that the facilitative generalist nature of the work might cause this, as well as the lack of immediate concrete outcomes. Work in partnership with others was perceived as low value even within nursing. However, the authors found that nurses engaged in public health work felt that it was valuable and worthwhile. The nurses felt they made a difference to people's lives. They felt they had a broad understanding of health and the community, and the interrelationship with the individual and the community, especially the resources within the communities. For many there was a family focus in their work which helped them get to know the community. Nurses were positive about working in partnership to develop client strengths, enhance self care and use opportunities for teaching. They said that public health nurses go to the public, whereas in other aspects of nursing and medicine the public comes to them. Making a difference was determined by positive changes in clients health practice or health status, increased client self care and responsibility. They regarded availability in peoples own environment as an important attribute. Credibility with clients was also important, with nurses seeing themselves as less threatening and less judgmental than doctors. In discussion, Reutter and Ford highlighted a number of issues in relation to public health roles in nursing. In order to justify public health work there is a need to measure effectiveness. However, the invisible nature of much public health work makes this difficult. Outcomes considered are often long term. However, short term outcomes could be measured more successfully. Reutter and Ford suggested a need to set priorities for public health, indicating that a generalist role might cause role confusion, with public health nurses filling gaps in service provision. They

indicated that in Canada public health nurses had begun to decrease their involvement with families where there was high risk but no chance of change. However, public health nurses in Canada would also like to become more involved in community development work. Finally, they suggested that their study highlighted the need to market public health nurses' services effectively - so that other professions were aware and valued them.

In another study from Canada, Beddome et al (1993) describe a survey which sought to clarify public health nursing roles for the future and the issues public health nursing in Canada is facing. Their findings outlined a vision which fits with a broad conceptualisation of primary health care (WHO 1978) and community development concepts, and which has implications for practice and education. Ten key issues were uncovered. Respondents felt that more dollars were needed for prevention. They believed that public health nurses would need to become more involved in community health planning. They suggested that individuals would take greater responsibility for health at macro and micro levels. It was proposed that in the future, community services would be more integrated with other health services, and that there would be more definition of roles and promotion of roles in public health nursing, together with better working conditions. There would also, respondents thought, be more emphasis on enabling for empowerment, and increased education of the public about health issues and rights to health care as well as the roles of public health nurses. Respondents suggested that research on qualitative aspects of public health nursing outcomes was needed, and indicated a need to build up teamwork, intersectoral collaboration, and liaison with government at regional level. The authors considered the educational implications of their work and suggested that Canadian nurse education needed more orientation toward primary health care principles and public health. They also felt that a strategy to promote interdisciplinary education would help intersectoral collaboration. Specific topics identified as necessary were community development, primary health care, self care, community assessment, health care planning, research and political skills.

Although there is an extensive literature on public health nursing from the Scandinavian countries, papers do not appear to have addressed the developmental debates which have appeared from Canada. Research has focused on specific aspects of public health nursing practice. For example, in 1994, Vehvilainen-Julkunen looked at the function and meaning of home visits versus clinic contacts by public health nurses in Finland, concluding that the most important function of home visits was to support and encourage parents of young children and to ensure continuity of care (Vehvilainen-Julkunen 1994). In a paper with Duffy and others (Duffy et al 1998) Vehvilainen-Julkunen compared Finnish practice (36 nurses) with that in the United States (30 nurses). She highlighted the capacity of the Finnish system to enable nurses to develop long term relationships and thus advance family centred practice. Paunonen (1991) looked at the effects of a nursing supervision programme on public health nursing practice in Finland, finding that the nurses perceived that their freedom of action and willingness to act, as well as their nursing activity were greatly improved following supervision (Paunonen 1991). Papers from Australia (Labonte 1989, Gibb 1998) have explored the impact of public health reforms on nursing. Gibb concludes that though the changes pose a challenge to maintaining standards amidst resource cuts and restructuring, the processes through which these changes occur and

the decisions which drive the reforms remain complex and largely obscure. A way of understanding the policy 'reform' process is offered, through an application of policy analysis grounded in critical social theory. The discussion applies this analysis to examples of change in the nursing workplace, and focuses on the implications for nurses.

2.5. Different Community Specialist Practitioners

This study is concerned (mainly) to examine the preparation for and public health work of three groups of community specialist practitioners: health visitors, practice nurses and district nurses. The literature on public health work by these groups is strongest in relation to health visitors, yet relies extensively on qualitative studies, and studies which have mainly explored process. Most of the relevant literature predates recent policy shifts. In a paper published in 1997, Cowley discusses two contradictory articles debating the future of health visiting practice (Cowley 1997). The first suggested that health visiting cannot meet the 'testability' criteria required for randomised controlled trials to ensure that activities are effective. Since an 'evidence based NHS' should only fund activities which demonstrate effectiveness, the article proposed that managers direct health visitors away from preventative strategies into the clinical care of people with established disorders, or into some of the work carried out by doctors. In contrast, the second article highlights it's author's perception that despite expansion in health promotion health visitors were becoming increasingly marginalised in the NHS. It suggests that the loss of health visiting would be a great disaster for an effective preventative health care system.

In her discussion of the debate, Cowley highlights the continuing tension as to whether a collectivist or individual focus should prevail, and suggests that much less attention has been directed to the point where these perspectives meet. Health visiting, she suggests, bridges that gap. She argues that health visitors are well placed to facilitate public health action without being limited by the constraints of the traditional epidemiological focus. She suggests that the requirement for health visiting to obtain contracts by marketing their services focused the minds of practitioners on evaluation, and away from the principles first developed in 1977 and found to be still relevant by Twinn and Cowley in 1992 (Twinn and Cowley 1992). De la Cuesta's research describes the 'fringe' work of health visiting, in which health visitors identify needs which are beyond their official contract and respond to them (de la Cuesta 1994). In her own work, Cowley indicates that health visitors especially in GP fundholding practices were not able to respond as flexibly to identified health needs as they wished, because they were held in a more restrictive contract, thus limiting their practice potential. In addition, she suggests, there is (in 1997) no formal acknowledgement of the family or the community in the NHS, only individuals and populations. As a result family and community group work becomes invisible, and there is no time allowance. Cowley suggests that health visitors seek to avoid a problem orientated focus and instead encourage the use of resources for health.

Looking more specifically at community development within health visiting, Dalziel (1994), in a personal account explains how she attempts to integrate a community development approach into routine work with families and children. Craig (1995) describes the work of four health visitors working in community development in Scotland. She indicates that the people described felt they had little support from

management. Their posts were regarded as extra to generic health visiting. Secondments were usually based on requests by individual projects rather than a strategic direction. She describes confusion about the role in terms of relevance, and little knowledge of theory. The type of work undertaken included a wide range of tasks from training and supporting volunteers and their initiatives eg. around play areas, through the development of a home loan safety equipment scheme to participation in local forums and securing urban aid funding. Craig points out the close association between community development and health visiting in that:
'Both use a broad definition of health and a holistic approach, develop action based on need, recognise the importance of social support and networks, and emphasise the development of the individual's potential to achieve health.'
In a small qualitative study, Graney (1998) explores health visitors' perceptions of the relationship between community development and routine practice, and lists some of the barriers identified by them.

Little is written concerning the practice nurse as a practitioner of 'public health', health promotion or prevention. Most studies have been descriptive, giving an overview of the role, together, often, with some analysis of training needs. One recent survey based study looked specifically at practice nurses' work on health promotion, and concluded that it was relatively superficial in nature (Mackereth 1995). Other work has suggested untapped areas in which there is potential for a greater preventive role (Crosland and Kai 1998). As for district nurses, again the literature is largely descriptive, or engaged in exploring the care of people with chronic problems or terminal illness (Lange 1996) (Bond et al 1990). Looking at prevention, most studies have looked at aspects of secondary or tertiary prevention with individuals and at the prevention of organisational problems such as poor discharge, rather than at wider public health issues.

2.6. Effectiveness in Relation to Public Health and Health Promotion

Effectiveness in relation to work in public health and health promotion is a difficult area to assess, partly because of the timescale over which outcomes may be expected, and partly because if events are prevented, they cannot be counted. Barriball and Mackenzie reviewed the literature on measuring the impact of a variety of nursing interventions in the community (Barriball and Mackenzie 1993). They indicated that it was important to consider the validity of the criteria used to assess outcomes in the community setting study, referring to a study by Barkaukas (1983) whose study of the effectiveness of home visits to primiparous mothers and their infants demonstrated no significant difference in health outcomes between those visited and those not . They suggested that further research was needed to test reliable and valid methods of outcome measurement.

In the United States David Olds and colleagues (Olds et al 1998) undertook a fifteen year follow-up of a randomised controlled trial which compared developmental screening only with developmental screening plus a programme of home visits by nurses. 400 families took part. 85% were young, unmarried, or of low socio-economic status. The nurses focused on three areas of intervention: positive health related behaviour, competent care of the children, and maternal personal development. They undertook an average of 9 visits during pregnancy and 23 from birth to the child's

second birthday. At fifteen year follow up, adolescents in the intervention group reported significantly less serious anti-social behaviour and substance misuse.

Jane Robinson completed a systematic review of domiciliary health visiting for the NHS Health Technology Assessment Programme, which has been briefly reported (Robinson 1999) though full publication is expected in early 2000. She and her colleagues concluded that health visiting was a universally acceptable service and that its effectiveness had currently been demonstrated in a limited number of areas of activity. They suggested that further work was required.

Stewart-Brown and Prothero looked at approaches to evaluation in community health development (Stewart-Brown 1988). They suggested that there were three areas for consideration. Firstly, specific health indicators such as infant mortality could be monitored. However, this could not be done at an electoral ward level. Secondly data on measures of the health status of communities could be gathered before and after intervention. This might include measures such as the Nottingham health profile, maternal malaise indicators, and self esteem profiles. However, there was a danger that this approach could alienate communities by appearing to 'objectify' them. Thirdly, changes in health service usage could be collected, though changes could be difficult to interpret. These authors noted that community workers sometimes considered it inappropriate to evaluate their work using quantitative data. However, the use of qualitative and quantitative data in combination could raise credibility with managers.

A Canadian team, Ciliska et al (1996), undertook a 'systematic overview' of evidence for the effectiveness of public health nursing interventions carried out through home visiting. Having looked at 108 articles, 9 were judged to report strong studies. These reported no negative effects of home visiting. Positive outcomes included improvement in children's mental development, mental health and physical growth, reduction in mothers' anxiety, depression and tobacco use, improvement in maternal employment, nutrition and other health habits, government cost saving and a reduced level of care needed for older people.

Twinn and Shiu (1996) undertook an evaluation of the effectiveness of public health nursing, looking at a case study of maternal and child health centres in Hong Kong. They suggest that to measure outcomes it is essential that an accurate data base of identified health needs is available from which the effectiveness of care can be monitored. Without a database developed from relevant health and social data, nurses can only draw on perceptions of health need. It is however impossible to assess the degree to which needs have been met if they are inaccurate in the first place.

This is also the case in relation to the recommendations of the Standing Nursing and Midwifery Advisory Committee (SNMAC). In their report, *Making It Happen* (1995) they highlighted the importance of the health benefit cycle as a framework for evaluating methods and systems for promoting health in communities. The cycle consists of seven key steps:

1. Defining the health problem
2. Identifying potential solutions

3. Agreeing health priorities and outcome objectives
4. Specifying interventions and standards required
5. Delivering the interventions
6. Auditing the processes of delivery against the standards specified
7. Re-assessing the health problem after delivery of the intervention

These had been suggested as an appropriate tool by the Central Health Outcomes Unit. As can be seen the cycle is dependent upon the definition of a particular health problem and its re-assessment after intervention, requiring measures which can distinguish appropriate levels of change.

2.7. The Educational Preparation of Practitioners for Public Health Roles

Though this study is focused around the practice of public health, it is also centrally concerned with the process of education which generates that practice. Bramadat and colleagues (1996) used 27 focus groups of community practitioners to explore the knowledge and skills required for community health nursing practice, including public health nursing. Bramadat's team's results fell into five groupings - conceptualisation, process skills, personal qualities, curriculum content and practice experiences. In order to conceptualise practice, community health nurses need confidence, assertiveness, and strong communication skills. They need to 'view the community as a whole.' They need to be more aware of community resources and be able to co-ordinate their role with other agencies. They need an epidemiological knowledge base. The concept of client responsibility was seen as being about working with and not for clients, and recognising that clients' priorities may be different. The process skills required included nursing process skills, assessment skills, (functional as well as overall health assessments), a greater emphasis on assessing client/family/community outcomes, strong communication skills, interviewing, negotiating, networking skills, group work skills, counselling and teaching skills, critical thinking and problem solving skills, management and leadership, technical and clinical skills, and acute care skills. The personal qualities required by community nurses according to these respondents included interest, creativity, maturity, confidence, diplomacy, negotiating skills and flexibility. In terms of curriculum content respondents suggested that there should be less emphasis on medical model/experiences, and that skills should look beyond individual work to family group dynamics, working in peoples homes, therapeutic work, specific client group work, family theory, environmental health, community development and adult learning theory. Community development was seen as complex. In addition the curriculum should address primary health care (as defined by the WHO)and health care policy, with emphasis on disease prevention and health promotion. Practice experiences should combine urban and rural experience, provide a clear definition of community health nursing, and an understanding of different philosophical approaches. Bramadat and colleagues suggested that for public health work, group and committee skills needed to be strengthened, together with assessment skills.

2.8. Interdisciplinary Approaches to Preparation

More recently, a document has been produced by an 'expert group' which has drawn on a wide array of sources in developing a proposed interdisciplinary curriculum for specialist public health work. This was the *Feasibility Study Of The Case For*

National Standards For Specialist Practice In Public Health (Lessof 1998) (Appendix Five). The NHS Executive commissioned this report to investigate how national standards might help establish and maintain a strategic focus for the specialist public health function in England. It built on the notion that public health works most effectively through multidisciplinary and collaborative partnerships which cut across professional and organisational boundaries. Whilst promoting the health of the public depends upon shared capability to which many professions and professionals contribute, there have been no clear criteria for specialist public health roles to provide effective and expert leadership. The report was developed following a series of interviews and a review of relevant literature and standards in place in related fields. A purposive sample of senior individuals, employers and training commissioners were interviewed as to whether and how they might use national standards for public health.

The authors concluded that there was demand from employers and employees for standards that would define the core of specialist practice and inform the development of the appropriate skills that relate to it. They wanted guidelines on best practice and help in devising a framework for benchmarking. Key roles for these standards would be to:

- Define boundaries for specialist public health, without imposing undue constraints on its growth;
- Establish a clear vocabulary and set of expectations about public health to allow different organisations to share reference points and interact more effectively;
- Provide career pathways and a development framework for individuals who wish to develop careers in specialist public health, which will also inform employers and support the selection of the best qualified and most effective practitioners to take responsibility for the public's health;
- Define the nature of the outcomes that can be expected so that organisations and specialists can begin to address the quality of their services and outputs;
- Create a means of monitoring and evaluating institutional and individual performance which may in the long term allow specialists to review their impact on the public's health and well-being. (p5-6)

The report suggested that completion of a functional analysis and the development of national standards would create national consensus around a set of statements to spell out the core values underpinning public health work, define key outcomes and roles and articulate the distinctive specialist role within public health. However, it was also noted that such standards would need to be acceptable to the various disciplines and professionals involved (including nursing) and equally applicable to the various organisations, sectors and individuals concerned.

It was suggested that standards should be developed which focus on the outcomes of specialist public health. They should also be developed in a way that would make it possible to monitor, and evaluate their implementation and use in practice. Updating would be crucial in the light of the constantly changing public health agenda. The report concluded that a multidisciplinary group, including all (or most of) the relevant professional bodies, representatives of employers, training commissioners and practitioners should be asked to:

- Develop outcome oriented *national standards* applicable to individuals and organisations using the working definitions and outline framework in this report
- Set up sustainable systems to implement, monitor, evaluate, review and update standards
- Devise a plan for the development, launch and piloting of standards
- Establish an approach to accreditation that dovetails with the setting of national standards. (p7)

Appendix One sets out the outline standards which the document proposes as a 'starting point for discussions of a suitable framework'. These fall under the following headings:

- Understanding health and disease; measuring health status
- Disease surveillance and control
- Promoting health and wellbeing[1]
- Evaluating and improving the effectiveness and efficiency of health care
- Evidence based decisions, information management and research
- Advocacy
- Communication and co-ordination
- Intersectoral and collaborative working
- Management and leadership
- Modelling the future of public health

The report goes on to suggest that a group should be formed to progress the development of draft standards and to devise an appropriate development plan. Further the authors suggest that the development of a system of accreditation should be dovetailed with the establishment of national standards.

2.9. The Initial Preparation of First Level Nurses

Nurses entering post-registration programmes are, increasingly, prepared in a different way to their predecessors. Concern about the initial preparation of first level nurses dates back to concerns about demographic change, and the development of the 'Project 2000' curriculum. Within this curriculum there was intended to be more exposure to community based practice, and to health promotion and prevention. However, though this did increase, most people completing the course remained based in hospital settings. Some of the possible reasons for this are explored by Carr, who examines how pre-registration students are taught about community practice (Carr 1999).

Nevertheless, the demands of health and social care are changing. In March 1998, the UKCC set up a Commission to review initial preparation for nursing and make recommendations for the next decade. This reported in September 1999 (UKCC 1999), in essence seeking to review and consolidate the original intentions of the architects of 'Project 2000'. The recommendations made fell into three areas. Firstly

[1] It would be inappropriate to seek to detail the way health promotion should be practised since it is already governed by a comprehensive set of standards. However, standards for public health would be incomplete were they not to set out the importance of health promotion and to recognise and be informed by the existing guidelines.

they sought to establish a more flexible approach to pre-registration education, by enabling health care assistants and others to enter nursing through a series of accredited pathways, and at the same time expanding graduate entry. Secondly the Commission sought to strengthen practice based education in the face of anecdotal evidence which suggested that newly qualified staff nurses lacked practical 'skills literacy'(p34). Proposals here related to the development of outcome based competencies, use of a portfolio of practice experience and the development of rigorous practice assessment tools. In addition, a minimum 3 month period of supervised clinical practice was proposed at the conclusion of the course. The third group of recommendations related to making explicit factors contributing to the establishment of effective partnerships between higher education and health care providers, between different groups and professions involved in delivering health and social care, and at government level. Disappointingly, because of the timescale involved, although the Commission recommended that the core foundation programme should be shortened to one year, they did not make any recommendations about the restructuring of the branch programmes to reflect the changing nature of health care.

2.10. Summary

This chapter has provided an overview of literature concerned with public health nursing education and practice. It began by looking at the nature of public health work in nursing. Key features included the importance placed on collective and collaborative action and the expectation that nurses undertaking public health roles would utilise a public health perspective which engaged with the social, organisational and policy aspects of health development as well as medical concerns. Effectiveness in relation to work in public health and health promotion was examined. It was concluded that this was a difficult area to assess. Accurate needs assessment was an important precursor to the measurement of outcomes. The importance of the health benefit cycle as a framework for evaluating methods and systems for promoting health in communities was highlighted.

The knowledge and skills required for community health nursing practice, including public health nursing were discussed. These were set alongside proposed multi-disciplinary standards for specialist practice in public health. It was noted that nurses entering post-registration programmes are, increasingly, prepared in a different way to their predecessors. The findings of the UKCC's Commission to review initial preparation for nursing were briefly reported. Their recommendations fell into three areas, encompassing flexibility, practice and partnership, but not in essence changing the nature of 'public health relevant' areas.

CHAPTER THREE

3. METHODS

This chapter sets out the aims and objectives of the study, and gives an overview of the methods used.

3.1. Aims of the Study

In this project, the study team has sought to explore three areas. Firstly:

- ***To evaluate the effectiveness as demonstrated in practice, of the key learning outcomes of a range of specialist practitioner programmes***

This required exploration of measures of effectiveness in practice, seeking to use the framework offered by the health benefit cycle (SNMAC, 6.4). It also required examination of the public health learning objectives identified by programmes, and the ways in which these matched the achievements described by individual graduates. Secondly, the study team sought

- ***To explore the developmental implications for the role of the specialist practitioner in the context of public health***

In order to address this aim it was necessary to examine students', course teams' and service managers' perceptions of current and future roles involving a public health remit, in order to determine an agenda for service development. The perceptions of service providers were also important in order to determine the nature of the current work environment. Thirdly we hoped:

- ***To analyse the implications of developments in post-registration education for pre-registration education and practice***

It was necessary in the first instance to explore possible developments in post-registration education for public health roles. It was then intended to examine the pre-registration provision required to underpin this, and identify any potential areas of duplication or shortfall.

3.2. Methods

3.2.1. Research Design

Reflecting and investigating the complexity of education and practice in a field which is itself undergoing rapid change requires a research design and methodology which is focused on key issues and which provides depth and detail in their exploration. At the same time, however, the study must also place this data in the context of wider developments and patterns.

In order to address these considerations, the study was designed in three strands. The first two, a study of courses and practice settings, sought to provide a broad overview of developments in the development of public health nursing, while the third strand, a series of case studies which brought together educational and practice settings, practitioners and students, allowed a more detailed exploration of the processes of curriculum delivery and practice development. The design is represented in the following diagram:

Strand One - Courses	**Strand Two - Practice Settings** *Nominated/identified by respondents in Strand One*
• Questionnaires to course/programme leaders • Course Documentation	• Questionnaires to Directors of Nursing or equivalent • Job descriptions
Strand Three - Case Studies • Curriculum documents • Policy documents • Interviews/focus groups with stakeholders • Public health practice logs • Contact lists	

3.2.2. Strands One and Two - Questionnaires

In Strands One and Two of the study the organisation of the curriculum and public health practice were explored using questionnaires and secondary data sources. The questionnaires were designed to provide an overview of the characteristics of the population being sampled. The choice of questionnaire methods as an initial approach to educational and practice settings was determined by resource and methodological considerations. Questionnaires are undoubtedly a cost-effective way of collecting basic data, particularly from geographically distant sites. Furthermore, acceptability to respondents is likely to be higher than for other approaches, for example face to face interviews, which can be intrusive and time-consuming for respondents. Questionnaires which asked straightforward questions or require easily accessible information, and which can be completed at the respondents' convenience are likely to produce more data than interviews which respondents might be unwilling to participate in.

Another consideration in the design of the questionnaires was the degree to which they should be structured. While some factual information was most appropriately collected by structured questions, it was also felt important to allow respondents the opportunity to make comments in a less structured way. The questionnaires therefore contained a mix of open and closed questions. A consequence of this decision was that questionnaires were relatively lengthy, producing problems for some respondents in identifying adequate time for completion. When completed, they also included a considerable amount of qualitative as well as quantitative data, producing issues for the research team in analysis.

3.2.3. Strands One and Two - Secondary Data

A number of secondary data sources were identified in the study design. These included, for the initial phase of data collection, curriculum documents, policy statements and job descriptions for public health nursing posts. There are a number of advantages of using secondary data, defined by Glaser (1963) as " Existing data which were originally collected for other purposes." The most obvious is that these materials are not shaped by the research process, in other words while responses in interviews or questionnaires or activities observed may be subject to "researcher effect" in ways which are difficult to evaluate, secondary data is not. It is, however, affected by other considerations - curriculum documents or policy statements cannot be taken as straightforward reports or records of what is happening, but must be recognised as products of particular political and social processes (Reed 1992). For these reasons, secondary data need to be considered in relation to other forms of data.

As information which accompanied the questionnaire data in Strands One and Two of the study, however, secondary data provided further information which would have been time-consuming for respondents to transfer into their questionnaire responses. It also allowed access to data which indicated the way in which some of the principles and issues identified in the questionnaire response were operationalised in teaching and practice documents.

3.2.4. Strand Three - Case Studies

These considerations suggested the utility of using a case study design for the study. The aims of the study recognised the importance of interrelationships between educational programmes and the practice settings in which students worked. These, it was anticipated would vary in different settings, as programmes developed in different ways, and practice settings were shaped by and responded to local and national issues. In order to explore these dynamics in any meaningful way, it made sense to try to look at educational programmes and practice settings together, rather than to collect data on samples of educationalists, students and service providers in a more general way which was not linked closely to contexts and relationships.

Miles and Huberman offer a definition of a case which is "a phenomenon of some sort occurring in a bounded context. The case is, in effect, your unit of analysis" (p25) (Miles and Huberman 1984). This definition points to the implications for case study design, which are, principally, that the phenomenon must be clearly identified and the boundaries to the case must be specified. In contrast, Yin suggests that a case study is 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context *are not* clearly evident' (p13) (Yin 1989).

This study used cases whose boundaries were defined on largely organisational and geographical grounds. A case consisted of an educational programme, students who had participated in it, and the practice setting in which they worked, and the relationships between these were the phenomena to be studied. Defining the case was,

however, a less than straightforward process, where educational programmes served a wide range of practice organisations, for example more than one trust. These could cover a wide geographical area, and so cases had to be defined to include only one coherent and accessible practice setting.

Miles and Huberman represent the case diagrammatically, using the idea of a "heart" or a focus to a case. Adapting this diagram for this study, we have the following diagram:

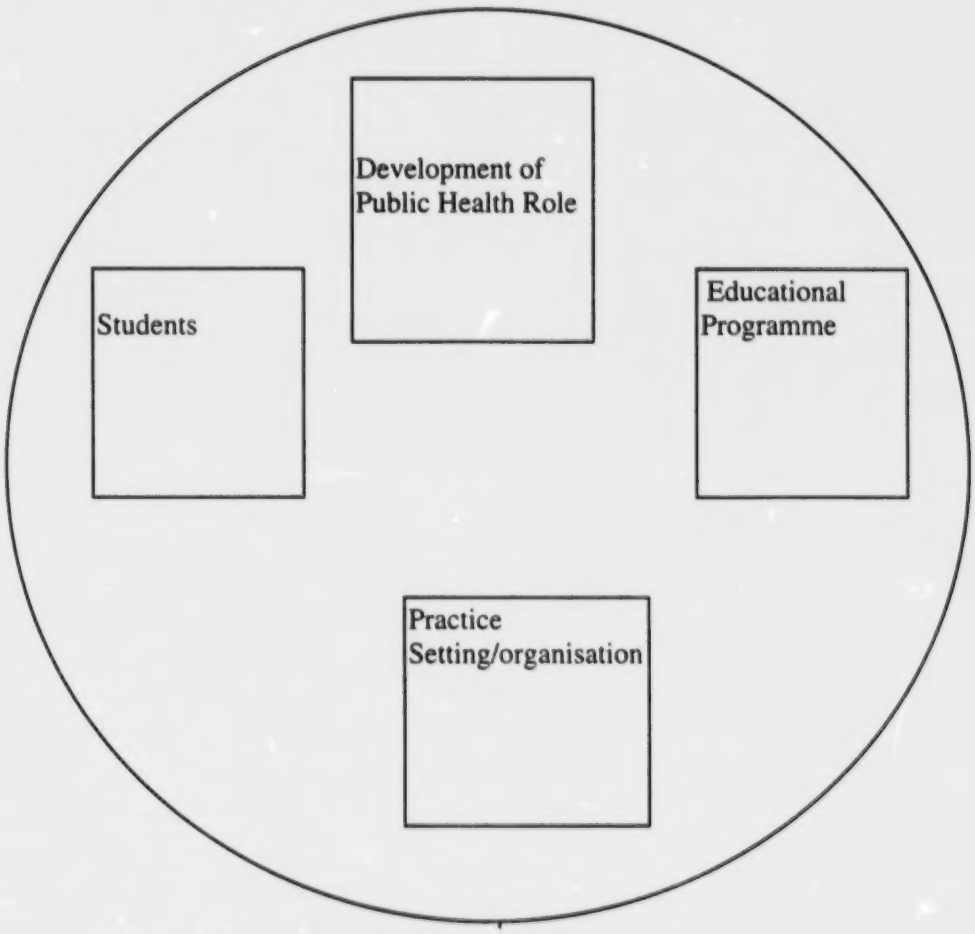

Figure 1 Case-study framework

A case study approach was used in this study to investigate the phenomenon of preparation for public health nursing in its real life context. Public health nursing is a complex activity, and preparation for this role is embedded within preparation for a variety of wider roles. The presence of multiple stakeholders (educators, managers, practitioners and indeed patients) and an extended time period in which development occurred required data to be collected from multiple sources, and brought together to provide triangulation. The study sought to address the question 'What are the

outcomes for public health practice of district nursing, general practice nursing and public health nursing/health visiting educational programmes?' A multiple case design was used, with each case selected to offer a different perspective on the phenomenon of 'education into practice.'

3.2.5. Strand Three - Sampling of Cases

The selection of case studies is of crucial importance if a study is to answer the questions that have been set. This requires purposive sampling which is directed by the aims of the study, rather than random sampling which is appropriate for studies in which the notion of generalisation to the study population are couched in terms of probability, and analysis is statistical.

Patton (1990) describes a number of different variations on purposive sampling which have relevance to this study. For example, it is possible to sample purposively to obtain maximum variation in cases, or to triangulate data, or to explore particular issues in depth. There is a distinction to be made between sampling strategies which develop as the study progresses, as initial data collection indicates promising areas to pursue, and sampling strategies which are determined before data collection begins. While the former allow flexibility of response to new findings and ideas, they require a flexible timetable for the study, in which deadlines are open-ended. The latter type of sampling strategy, which is determined before the data collection starts, may be less flexible, but it clarifies data collection and project management, particularly where there are firm project deadlines. For this study, it was decided that determining the sample of cases was a task which had to be completed early in the study, in order that targets and objectives could be met.

All but the most inductive sampling strategies involve some knowledge of the population from which the sample is to be drawn. In this study, in order that sampling could be purposive, and reflect the research questions, some data had to be collected first. This was done firstly through the questionnaires to educational establishments who provided the courses identified in the study remit and service providers who seconded or employed students in Strands One and Two. These questionnaires fulfilled two functions. Firstly background data was collected which contributed to the research aims, in developing understanding of the broader context of the development of public health nursing. Secondly, the questionnaire collected data which was then used to identify the sample of case studies.

The process of using the questionnaire data to select the sample of case studies was facilitated by the use of a sampling matrix (Reed et al 1996). In this the key criteria for sampling were laid out on the horizontal axis of the matrix, and as questionnaires were returned, respondents were entered on the vertical axis. Scores or descriptors for each criteria were entered for each respondent. The detail of this process is described below, but the principles are that it enables researchers to make explicit and critically evaluate their choices for sampling. In this way the matrix provides a useful check that the sample reflects and leads from the aims of the study, rather than being an impressionistic process, or based on expediency or convenience.

3.2.6. Strand Three - Interviews and Focus Groups

Using a case study design entails that the data collection processes or tools are, as far as possible consistent across cases, although case-specific data may be collected in limited ways. The standardisation of research tools enables comparisons to be made across cases, and differences and similarities to be identified. Another important consideration was the feasibility of any research design chosen. Accessing data from a wide range of sources and people, is a difficult process, particularly if study sites are geographically distant and a continuous researcher presence is not possible. In choosing tools the research team was concerned to ensure, as far as it was possible to predict, that these would be effective in collecting appropriate data.

Data collection was, not, however, simply determined by expediency, in other words by what data was easily available. Data collection and methods had, first and foremost to collect data which would answer the research questions of the study. As these were about the relationships between courses, students and practice settings, data collection had to include information on two principal areas. The first area was the structural elements of each case, in other words the design of the courses and the curriculum, the characteristics of the students, and the organisational layout of the practice settings. The second element was the processes involved, in other words the ways in which the curriculum was delivered and evaluated, and the way in which public health was facilitated in the practice settings.

This division of structure and process, is, of course, a division which simplifies the research questions to an extent which could lose sight of the complexities or grey areas involved in developing the public health role of nurses. Nonetheless it proved a useful way of thinking about data collection, and a starting point for research design. What it pointed out was the possible range of data sources, and what they could offer the study.

The questionnaires and secondary data sources used in Strands One and Two of the study provided some information about structural aspects of the educational and practice settings. In order to explore processes in more depth however, the Strand Three case studies involved the use of interviews and focus groups with key stakeholders. In addition, students who had recently completed the courses were included in the case studies, in order to elicit their views and experiences of public health education and practice.

The use of interviews allowed some of the issues mentioned in the questionnaire data to be explored in greater depth, and the implications for education and practice, as respondents saw them, to be investigated further. Focus groups were also used in the study as a means of eliciting the views of practitioners and students. Focus groups can be advantageous in a study in pragmatic terms, as they increase the number of participants in a study without increasing researcher time. They are not, however, simply a matter of getting more data in a shorter time - several authors have pointed out that the interpersonal dynamics of focus groups make the data qualitatively different, in that what emerges is an insight into group debates and views. (Kitzinger 1995) (Reed and Payton 1997). While some recommendations for focus groups advise against including members who know each other, to avoid prior relationships

colouring the data (Mendes de Almeida 1980), this was neither possible or desirable in this study. While the focus group members might not know each other, their names having been provided by course leaders and trusts, it was possible that they would have had some contact before the focus group. This was not seen as a disadvantage, because, unlike focus groups in market research, the study was not looking for spontaneous responses to questions or ideas, but was interested in how practitioners as a group, had experienced public health nursing. To progress this exploration, the discussion of experiences against a shared practice background was judged likely to be facilitative rather than obstructive.

The case studies did not involve direct observation of teaching or practice. The constraints of time and resources in this study made this research strategy difficult to utilise, as did the problems of negotiating access and ethical approval. Such observation would have involved clients, whose consent would have to be sought. Aside from these considerations, the decision to use observation could only be justified if there were clearly observable phenomena to observe, and it was not clear that this was the case. While it is arguable that direct observation may have identified behaviour and practice which fitted in with definitions of public health practice, the meaning and rationale for activities could only be determined through discussion with practitioners, and it was this discussion which would increase understanding of the processes of developing a public health role.

Nonetheless, it was desirable to have some data directly from practice, as a way of grounding discussion, and this was achieved by discussing specific incidents in the focus groups, and by asking practitioners to complete a "public health practice log" over a period of a month prior to interview. These strategies were not proxies for direct observation, nor is it claimed that they provide evidence of actual behaviour in practice, but they offered an opportunity for practitioners to discuss public health nursing issues in less abstract ways, which were linked to practice.

3.3. Timetable of Study

One important footnote to the study design must be the impact of policy shifts on the study. At the beginning of the study, in April 1997, a Conservative government was still in power, and still developing a policy for primary health care based around the internal market, with little attention to 'variations in health'. At its conclusion, a Labour government had been more than two years in office, and was pursuing an active public health focus across a range of relevant departments. Respondents' views need to be read in the context of documents which were and were not available at the time of data collection.

Date	Study activity	Policy developments
April 1997	Study begins	
May 1997	Obtained list of Institutions	New government
August 1997	Questionnaires sent out to Course/Programme Directors, Route Module Leaders	
September 1997	Reminder letter to Course/Programme Directors; Regional Nursing Directors contacted to provide list of nurse directors/advisers	
December 1997	Date for return of Course/Programme Directors, Route Module Leaders questionnaires Trust and Health Authority questionnaires sent out.	White Paper -*The New NHS, Modern, Dependable*
January 1998	Telephone contact offering a shortened questionnaire to Course/Programme Directors, Route Module Leaders Return date for Trust and Health Authority questionnaires	Public health Green Paper *Our Healthier Nation*
January 1998	Sampling matrix developed for Strand Three	
February 1998		Interim report: CMO project to strengthen public health function
June 1998	Piloting in strand three completed	
July 1998	Initial site contacts	
September 1998	Initial visit - multiple site	
November 1998	Follow up visit - multiple site	*Supporting Families* (Home Office)
December 1998	GPN site - visit	*Sure Start* (DfEE); Independent Report on Inequalities in Health (Acheson)
January 1999	District Nursing site - visit	
February 1999	HV site - visit	
July 1999		Public health White Paper, *Saving Lives - Our Healthier Nation*; Strategy for nursing, midwifery and health visiting, *Making a Difference*
September 1999	Report completed	

Table 1 Study timetable

3.4. Summary

In this chapter, an overview has been given of the study objectives. These sought to examine the effectiveness in practice of the key learning outcomes of a range of specialist practitioner programmes, and the developmental implications of these findings for the role of the specialist practitioner in the context of public health. In addition it was hoped to analyse the implications of the findings for pre-registration education and practice. The research design was described. The study was designed in three strands. The first two, a study of courses and practice settings, sought to provide a broad overview of developments in the development of public health nursing. The third strand used a multiple case design, with each case selected to offer a different perspective on the phenomenon of 'education into practice', bringing together educational and practice settings, practitioners and students, to allow a more detailed exploration of the processes of curriculum delivery and practice development.

CHAPTER FOUR

4. EDUCATION AND PRACTICE PERSPECTIVES

This chapter sets out the methods and findings for Strands One and Two. Strand One was a postal survey of people responsible for delivering specialist community practice courses in England. Strand Two was a postal survey of the views of senior nurses in each Health Authority and Trust in England about public health work in community specialist practice, now and in the future.

4.1 Strand One - Educationalists

4.1.1. Purpose

Strand one was a national postal survey of educationalists (course programme directors and route module leaders) in England and was designed to fulfil two functions. Firstly, it was intended to enable the team to identify innovative and proactive specialist practice courses with a significant interest in public health. Secondly, it was hoped to gather the views of those involved in education provision for this group about public health work in nursing, and about issues of importance in the design and delivery of current and future courses.

4.1.2. Piloting of Methods

Local piloting was carried out for each strand of the study. In strand one, two local universities were used to pilot a semi-structured questionnaire which would provide a mix of quantitative and qualitative data. The latter was felt to be important in exploring the views of this group about public health, an area about which little was known.

4.1.3. Accessing Sample

In May 1997 the project team obtained a list of Institutions who were running or were in the process of having courses validated to run the Specialist Practitioner Programme. The organisational arrangements within each institution varied, but most had two levels of staff involved in the direction of the course. In every institution there was an individual identified as the *Course or Programme Director* for whatever specialist practitioner programme was being offered. Institutions offered programmes which varied from a single route to several of the eight possible, so that the responsibilities, and indeed the seniority of this person could also be quite varied. The role as perceived at the pilot stage included making links with the local health authorities and negotiating with educational commissioners and the ENB about the programme offered. In addition, where more than one route existed, there was

normally one or more additional members of staff identified as leading each route, known as *Route Module Leaders*. These staff were often of less seniority than Course / Programme Directors. Their role appeared, at the pilot stage, to involve more contact with practitioners and first line managers.

Each of the institutions was then telephoned to obtain the name of the Course/ Programme Director. There were 40 sites in total, though not all were offering each of the branches with which the study was concerned. Questionnaires were drafted and pilot sites identified from amongst the research team's contacts. Following the pilot work, in August 1997 questionnaires (see Appendix 8) were sent out to Course / Programme Directors, enclosing colour coded questionnaires to the respective Route Module Leaders for District Nursing, General Practice Nursing and Health Visiting. In order to meet the project deadlines we asked that the questionnaires be returned by mid September. At the beginning of September, a reminder letter was sent to the Course/Programme Directors. However, due to summer holidays and the general poor response rate, this deadline was changed and re-set more realistically for mid December.

In November 1997, follow up telephone calls were made to try to chase up those Course Programme Directors who had not returned questionnaires or from whom no contact had been received.

In January 1998, further telephone contact was made offering a shortened questionnaire (which could be completed on the telephone or through the post) for those who had not responded to obtain a minimum data set of information in relation to each course. It became apparent that some Course/Programme Directors had not actually sent questionnaires on to the Route Module Leaders in the first place. Where questions were answered by telephone, there was time to explore some things on the phone in depth, but researchers felt that overall the breadth was lost. The geographical location of many universities was scattered, often around a very large area, including hospital training schools, and many different sites miles apart. This made it very confusing and difficult to access different Route Module Leaders. Many sites were not running all programmes, and some were awaiting validation.

4.1.4. Educationalist Response Rates

Out of forty potential programmes, two were used for piloting, and three did not have validation. This left 35 from whom responses were sought. Of these, ten Course Programme Directors responded, representing a response rate of 29%. Not all programmes had separate Route Module Leaders, nor did all centres run all three strands. Table 2 shows the response rates obtained for this group:

Health Visiting	18/34 = 50%
District Nursing	12/32 = 38%
General Practice Nursing	12/29 = 42%
(including 5.2% telephone and shortened postal responses)	

Table 2 - Route Module Leaders' Response Rates

4.1.5. Data Analysis

Questionnaires were coded between September 1997 and January 1998, and a preliminary analysis presented to the steering group in January 1998. Questions were treated in two ways: Questions 2, 7c, 8, 14, and 'additional comments' were transcribed verbatim and entered into a format suitable for analysis by NUD.IST. The remainder of the questions, to which responses were less detailed, were analysed using a modified content analysis approach and entered into Excel. Two researchers each coded independently. A sample of coding decisions was reviewed together after an initial coding period and on completion to identify variations and explore reasons for these. The initial analysis produced loose categorisations, for which frequencies could be counted. However, though such counts gave some idea of the strength of different ideas in the data, numbers create a misleading impression of stability when the allocation of many categories remained relatively flexible. They are therefore not provided in the data presented below.

4.1.6. Issues in Interpretation

The low response rates obtained, and the small numbers of respondents must be taken into consideration when interpreting the findings presented. The views of two or three individuals may seem to be more central than in fact they are, and issues such as geographical constraints or historical patterns of provision (for example previous levels of fund holding, or innovative practice) may influence responses in particular directions. The data presented is largely qualitative, and difficulties in the interpretation of qualitative data within a postal questionnaire, where probing for further clarification of terms is not possible, should also be noted. The research team sought to strengthen the reliability of the findings by separately coding and grouping a sample of questionnaires and comparing interpretations.

4.2 Key Findings from Strand One

The educationalists' responses contain a great deal of diversity, therefore the analysis focuses mainly on identifying the strongest and most common themes. The greatest depth and quantity of responses was given by the route module leaders for health visiting, which may reflect their own history, interest and beliefs in public health as a discipline.

Some of the main differences and similarities between the educationalists' responses are highlighted below:

4.2.1. The Major Priorities for Public Health Nursing

Course Programme Directors	Route Module Leaders - Practice Nursing	Route Module Leaders - District Nursing	Route Module Leaders - Health Visiting
Poverty/Inequity	**Poverty/Inequity**	**Poverty/Inequity**	**Poverty/Inequity**
Health promotion	Environment	Disease orientation	Commissioning services and policy development
Targeted groups	Collaborative working	Commissioning services and policy development	Health promotion
Disease	Health promotion	Health needs assessment	Environment
Community involvement and empowerment	Commissioning services and policy development	Targeted groups	Mental Health

Poverty/Inequity

The main priority for all educationalists was about targeting poverty and inequity in terms of employment, housing, education and health care provision.

"I see priorities in public health in the coming decade to ensure that disadvantaged and vulnerable client groups are able to secure enough of the scarce health care resources available to prevent some of the health problems created by poverty, homelessness and disability." RMLDN32

"there should be more emphasis on addressing inequalities in health and inequalities in access to health care. Housing, social work and health coming closer together." CPD9

"tackling the effects of poverty - inequalities in health amongst the unemployed, single parent families, homeless, ethnic minority groups." RMLHV28

Commissioning Services and Policy Development

Commissioning services and developing policy featured highly for route module leaders in health visiting and district nursing, but much less so for course programme directors and route module leaders for practice nursing. The main focus here was about re-orientating health services away from secondary care to primary and public

health care and also away from the medical model of health. Educationalists saw the need for practitioners to influence healthy public policies and develop public health strategically.

Health Promotion

Health promotion was a strong common theme in all but the route module leaders for district nursing.

"Educating the public, changing attitudes. Involve and encourage greater community participation." CPD28

"Making all community nurses aware of health promotion as a proactive part of their role." CPD40

"Continuation of the targeting of heart disease, stroke, HIV/AIDs etc - increase in focus upon TB, food poisoning and meningitis." RMLHV20

The District Nursing programme leaders focused more toward disease orientated priorities, for example cancer and heart disease.

Environmental Change

Environmental change was a priority in terms of pollution, transport and creating more supportive environments.

"Creating healthy environments, eg air, food, etc. for people to make health choices." RMLHV9

It featured as a key area only for the educationalists in practice nursing and health visiting, although it was mentioned by all respondents.

Differences

In terms of differences the route module leaders for health visiting saw mental health as a priority, whereas the other educationalists had this much lower in their list of priorities.

4.2.2. Foundations for Meeting the Public Health Needs

Asked about elements which would form the foundations for meeting public health needs, seven key themes were identified. Health needs assessment was seen as an important foundation:

"Root practice in the assessment of health needs at community, group and individual levels. This is a starting point for health promotion, developing practice and services as providers and contributing to the commissioning process." RMLHV1

Respondents also wanted to ensure that students had a socially rooted definition of public health. They wanted to see a shift from individual to population health underpinning future development. They believed that the practice environment was influential in creating a foundation for meeting public health needs. In addition, they believed that students needed a range of skills as a foundation for public health practice. Shared learning with other disciplines was seen as important in developing a public health approach. Recognition of limitations was also seen as a key element of a public health foundation.

4.2.3. Strengths of the Programme

Course Programme Directors	Route Module Leaders - Practice Nursing	Route Module Leaders - District Nursing	Route Module Leaders - Health Visiting
Clinical Links	Health needs analysis	Shared learning	Clinical Links
Shared learning	Shared learning	Clinical Links	Shared learning

The main common strengths were identified as shared learning through inter-professional collaboration and good clinical links with community practitioners and community practice teachers.

4.2.4. Weaknesses of the Programme

Course Programme Directors	Route Module Leaders - Practice Nursing	Route Module Leaders - District Nursing	Route Module Leaders - Health Visiting
Theory/practice conflicts	Time shortage	Theory/practice conflicts	External influences
Time shortage	External influences	Time shortage	Theory/practice conflicts

The main weaknesses identified appeared to be around the problems of integrating theory and practice. However, time shortage to deliver the programme adequately was seen as adding to this difficulty. External difficulties were described by the route module leaders for general practice nursing and health visiting as being about medical dominance and GP fund-holding.

4.2.5. Influences on Student Preparation

Course Programme Directors	Route Module Leaders - Practice Nursing	Route Module Leaders - District Nursing	Route Module Leaders - Health Visiting
National policy reports/ documentation	National policy reports/ documentation	National policy reports/ documentation	National policy reports/ documentation

National policy documents for example *The Health of the Nation* featured most strongly as influencing the preparation, however, a range of literature from professional and educational bodies was also mentioned, for example *Making it Happen* (SNMAC 1995), as well as international documentation for example reports from the World Health Organisation.

4.2.6. Public Health Functions

Course Programme Directors (for all disciplines)	Route Module Leaders - Practice Nursing	Route Module Leaders - District Nursing	Route Module Leaders - Health Visiting
Health needs assessment	Health needs assessment	Health needs assessment	Health needs assessment
Health promotion/ prevention	Health promotion/ prevention	Collaboration	Community involvement and empowerment

Health needs assessment was the most common and strongest identifiable public health function across all the disciplines. However, between the disciplines there was great variation. There was also variation in what the course programme directors and route module leaders believed to be the key public health functions for each discipline.

Public Health Functions - General Practice Nursing

Course Programme Directors	Route Module Leaders - Practice Nursing
Dependent upon Practice environment - GP influences	Health needs assessment
Disease management - screening, immunisations	Health promotion/prevention

Public Health Functions - District Nursing

Course Programme Directors	Route Module Leaders - District Nursing
Disease focus post-operative care ill-health focus chronic disease	Health needs assessment
Work with individuals	Collaboration (multi-disciplinary and multi-agency)

Public Health Functions - Health Visiting

Course Programme Directors	Route Module Leaders - Health Visiting
Health promotion/prevention	Health needs assessment
Health needs assessment	Community involvement and empowerment

4.2.7. Obstacles and Opportunities in the Work Environment

General Practice Nursing

Obstacles in the Work Environment

The course programme directors see the way in which care is organised as providing the main barrier to the development of the public health function for general practice nursing. This is described in terms of the individual and task orientated focus of the care with measurable outputs, clinical sessions and targets at the heart of the organisation of care. The route module leaders and programme directors describe the service as being restricted by the way it is managed through the general practitioners as fund-holders and employers of practice nurses and identify a lack of appropriate professional support and development, which links directly with how the care is

organised. Competing views and expectations feature strongly as an obstacle in that the work is strongly disease focused and medically orientated and that there is a lack of understanding of the broader public health role that practice nurses could fulfil. The route module leaders also state strongly that general practice nurses have a knowledge deficit in terms of public health.

Course Programme Directors	Route Module Leaders - Practice Nursing
Organisation of care	Management of the service
Management of the service	Competing views/expectations
Competing views/expectations	Education/training

Opportunities in the Work Environment

Course Programme Directors	Route Module Leaders - Practice Nursing
Team membership	Team membership
Working with a defined practice population	Working with a defined practice population

The opportunities to promote public health nursing are usually described in terms of having closer working relationships with the general practitioners and the rest of the primary health care team. The contact with the practice population is also seen as a great bonus to public health functioning in that all age groups are seen and that the population is well defined through the practice boundaries.

Health Visiting

Obstacles in the Work Environment

The main obstacles identified are described in terms of the competing views and expectations of health visiting. Health visiting is seen as being in conflict with the individual and disease orientated approach of the National Health Service. It is also felt that the service is stuck with a traditional role of working only with children and families. The public health role of health visiting is strongly described as not being recognised or understood. Within this, there is also a lack of consensus as to what constitutes public health in the context of primary health care.

Course Programme Directors	Route Module Leaders - Health Visiting
Competing	Competing

views/expectations	views/expectations
Organisation of care	Resources
Colleagues and team functioning	Management of the service

Opportunities in the Work Environment

Course Programme Directors	**Route Module Leaders - Health Visiting**
Professional development/scope of practice	Professional development/scope of practice
Team membership	Collaboration
Attitudes to public health	Team membership
Defined population	Management

The opportunities in the work environment to promote public health nursing are described by both groups in terms of the opportunities for the development of new ways of working and extension of the scope of practice. Doing this within a team of other disciplines is also seen as important by both groups, particularly route module leaders, who see collaboration with a wide range of disciplines as an important opportunity. The defined practice population is seen as an advantage by course programme directors in developing public health work, particularly as health visitors work with the whole population. Route module leaders regard aspects of the management culture - for example the contracting and commissioning processes - as opportunities.

District Nursing

Obstacles in the Work Environment

Obstacles are seen in broadly similar ways by both course programme directors and route module leaders. They relate primarily to the demands of current models of practice, and the competing demands of different aspects of district nurses' work - for example the need to carry out terminal care, or respond to acute situations.

Course Programme Directors	**Route Module Leaders - District nursing**
Organisation of care	Competing views/expectations

Colleagues/team function	Resources
Competing views/expectations	Organisation of care

Opportunities in the Work Environment

Course Programme Directors	**Route Module Leaders - District nursing**
Team membership	Management
Collaboration	Team membership
Defined population	Defined population

Course programme directors also view the opportunities within the district nurses' work environment in broadly similar terms to the relevant route module leaders. For both, membership of the multidisciplinary primary health care team is seen as leading to increased opportunities for district nurses to undertake public health work. Collaborative activity is seen as a positive advantage by course programme directors. Having a defined practice population is also seen as an advantage to public health functioning by both groups. Again, route module leaders see contracting and commissioning in a positive light.

4.2.8. Who Teaches Public Health?

Practice Nursing

In higher education settings, there was agreement between course programme directors and route module leaders that public health teaching for practice nurses was largely delivered by educationalists from a nursing background, with occasional other contributors.

Course Programme Directors	**Route Module Leaders - Practice nursing**
Educationalists	Educationalists
Community non-nursing practitioners	Medical staff
Community nurse practitioners	Community nursing specialist practitioners
Medical staff	Community non-nursing practitioners

In practice settings, both groups perceived the main agents of public health teaching for this group as community practice teachers.

Health Visiting

Again,.there was agreement between course programme directors and route module leaders that for health visitors, public health teaching in the higher education setting was largely delivered by educationalists, with specialist practitioners and others such as non-nursing community development workers contributing occasionally.

Course Programme Directors	**Route Module Leaders - Health visiting**
Educationalists	Educationalists
Community nursing specialist practitioners	Community nursing specialist practitioners
Community non-nursing practitioners	Community non-nursing practitioners

Both groups concurred that public health teaching in the practice setting for health visitor students was largely delivered by community practice teachers.

District Nursing

Once again, there was agreement between course programme directors and route module leaders that for district nursing students, public health teaching in the higher education context was largely undertaken by nursing educationalists. There was some divergence about other contributions to teaching, with route module leaders perceiving more practitioner involvement in the higher education setting, but both groups also saw a role for non-nursing community practitioners such as social workers.

Course Programme Directors	**Route Module Leaders - District nursing**
Educationalists	Educationalists
Community non-nursing practitioners	Community nursing specialist practitioners
Medical staff	Community non-nursing practitioners

In the practice setting, once again, both groups were in agreement that the major agent of public health teaching for district nursing students was the community practice teacher.

4.2.9. Developments or Innovations in the Programme

Course programme directors highlighted a number of innovative educational approaches in use in their institutions, including 'learning action groups', 'critical analysis' and multidisciplinary teaching. They also suggested that teaching about health needs assessment was innovative. Some commented that they sought to deliver a flexible and responsive course or programme, and others that it was 'too early to tell' whether their particular course was innovative. Route module leaders from all disciplines highlighted a wide range of innovations, again predominantly concerned with educational approaches, but also health needs assessment and strategies to address the 'theory-practice gap'. A few of the examples given are shown below.

Route Module Leaders - Practice Nursing	Route Module Leaders - Health Visiting	Route Module Leaders - District Nursing
Educational philosophy/theory • Shared learning • Multi-disciplinary • Problem-based	**Educational philosophy/theory** • Community development experience • Reflective practice • Shared learning • Emphasis on marketing • Empowerment module • Module on change management	**Assessment of needs** • Health needs assessment • Health needs analysis
Assessment of needs • Health needs assessment • Portfolio/profiling/reflective practice reports	**Theory/practice gap reduction** • Exploration of innovative practice • Case studies • Higher award • Involve field practitioners to reflect reality • Panel of guest speakers • PH survey locally with PHCTs	**Educational philosophy/theory** • Leadership development module • Shared learning
Theory/practice gap reduction • Alternative practice • ENB higher award • Practice teacher involvement	**Develop collaboration** • Emphasis on collaboration • Liaising with other agencies	**Broader view of health** • Environmental issues • Political/social issues
Broader view of health • Community perspective • Drop-in centre	**Emphasis on Public Health** • Increased emphasis on PH • Assessment of PH	**Expand scope for practice** • Applied specialist module • Critical analysis
Expand scope for practice • ENB autonomous practitioner • PH issues linked to chronic disease management	**Health needs assessment** • Community profiling • Mapping for health	**Health orientation** • Health education assessment • Health promotion
Technological • Information technology	**Other** • Good resources	**Theory/practice gap reduction** • Alternative practice • Linking policy with practice

4.2.10. Pre-registration Education as a Foundation for the Public Health Role

Course programme directors were asked how well they thought current patterns of pre-registration education prepared people for the public health role. Positive and negative aspects were described, with about twice as many respondents highlighting negative features as positive.

Positive	Negative
• Awareness raising • Essential ground work • Good preparation	• Variable • Inadequate • Need more sensitivity and synthesis • Too many students in the community

4.3. Strand Two - Health Authorities and Trusts

4.3.1. Purpose

Strand Two was intended to complement Strand One by gathering the views of senior nurses in each Health Authority and Trust in England about public health work in community specialist nursing now and in the future, about education for this work and about the strengths and weaknesses of public health practice.

4.3.2. Design

Local NHS contacts were used to pilot a structured questionnaire with mainly open ended questions, to help gather responses containing qualitative data. The questionnaire was developed and adapted from strand one to suit the practice context. A number of additional contacts were also suggested by the steering group and they were used to help inform the piloting process.

A national postal survey of trusts and health authorities was considered the most appropriate method of collecting this data. The questionnaires were designed to gather and collect qualitative data from open ended questions to allow exploration of the following areas:

- Public health work in community specialist nursing now and in the future
- Education for practice
- Strengths and weaknesses of public health practice

4.3.3. Accessing the Sample

In September 1997, each of the eight Regional Nursing Directors were contacted to ask for their help with the second strand of study. Each was asked to provide a list of nurse directors/advisers (or equivalents) in each Health Authority and Trust in England involved in the provision of community services. By the middle of October

this information had been received. However some of the information supplied needed to be clarified and in November the CPHVA were approached for an up-to-date list of Community Trusts. Once this list was received the team were able to check the information. In December 1997, Trust and Health Authority questionnaires were sent out (see Appendix 8). In order to meet the project deadlines we asked that the questionnaires be returned by the end of January 1998. A total of 286 questionnaires were sent out.

4.3.4. Response Rates

110 out of the 286 questionnaires sent out were returned giving an overall response rate of **38.4%.** The response rates by Region ranged from excellent at 64% to extremely poor at 23%. The data mainly reflects the views of senior nurses working in trust environments, partly because there are more trusts in England than Health Authorities and also because the response rate was better from the trust sample.

Response Rates for each Region

Regions	Total Issued	Response Rate
Anglia and Oxford	25	12 (50%)
North Thames	39	9 (23%)
North West	46	23 (50%)
Northern and Yorkshire	37	9 (24%)
South Thames	40	11 (30%)
South West	42	20 (48%)
Trent	25	16 (64%)
West Midlands	31	9 (29%)

Regional Trust and Health Authority Responses

Regions	Total Issued	Response Rate
Anglia and Oxford (25)	Trust = 14 HA = 11	Trust = 8 HA = 4 **(50%)**
North Thames (9)	Trust = 23 HA = 17	Trust = 6 HA = 3 **(23%)**
North West (46)	Trust = 29 HA = 17	Trust = 18 HA = 5 **(50%)**
Northern & Yorkshire (9)	Trust = 23 HA = 17	Trust = 7 HA = 2 **(24%)**
South Thames (40)	Trust = 26 HA = 14	Trust = 9 HA = 3 **(30%)**
South West (42)	Trust = 27 HA = 15	Trust = 16 HA = 4 **(48%)**
Trent (25)	Trust = 14 HA = 11	Trust = 10 HA = 6 **(64%)**
West Midlands (31)	Trust = 17 HA = 14	Trust = 6 HA = 3 **(29%)**

4.3.5. Data Analysis

The Trust and Health Authority questionnaires were initially analysed by recording the basic responses to each of the questions, which were often one word answers or very short sentences. Where there was a detailed descriptive response a note was made of this, so that more understanding could be attached to the basic data. The basic data was then reorganised by coding into groups which reflected common themes. A numerical scoring system was initially used to prioritise the themes within a region and identify the strength of the data within the themes.

Eg Region X.

Q2. **National Determinants of Major Public Health Priorities**

Top Theme - National Policy Documentation = 27 responses

Health of the Nation - 9
Primary Health Care White Paper - 6
Public Health Green Paper - 3
Environment/DOH 1996 - 3
Health inequalities/EL97 - 1
Children's Act -1
Welsh Policy -1
Health of Disabled/DOH - 1
Health and Safety/COSHH -1
Calman Report -1

However, though numbers can give some idea of the strength of different ideas in the data, they can suggest an inappropriate level of certainty. They are therefore not provided in the data presented below. The data was managed through the use of an Excel data base. Two researchers each coded independently. A sample of coding decisions was reviewed together after an initial coding period and on completion to identify variations and explore reasons for these. Once the data had been collated for each region, further thematic analysis was undertaken to identify the main themes for each region for each question asked and how common those main themes were. Common main themes were then collated to give the following responses. The collation of common themes was easier than it had been in Strand One as there was generally more agreement between responses in each region.

Findings for the whole sample are presented below, as in discussion with the project Steering Group it was felt that different Regions might experience different demands (for example balance of urban and rural population) or historical patterns of provision (for example previous levels of fund holding, or innovative practice) and might influence responses in particular directions. Since responses from health authorities were far fewer in number, division of the sample between health authority and trust respondents was also felt to present problems.

4.4. Key Findings from Strand Two

4.4.1. National Determinants of Major Public Health Priorities

- National governmental documentation
- Targeting of specific groups
- Health promotion strategies

The major influence identified in determining public health priorities by all health authorities and trusts was the information and direction received through national documentation, such as the Health of the Nation, Primary Health Care White Paper and Public Health Green Paper. The targeting of specific groups in the regions was also used by health authorities and trusts in all regions to determine priorities, children and families often featuring strongly. Health promotion strategies, such as smoking, accident prevention and sexual health again featured strongly as a major determinant of public health priorities.

4.4.2. Local Determinants of Public Health Priorities

- Targeting of specific groups
- Health promotion strategies

The targeting of specific groups was used by health authorities and trusts in all regions to determine local priorities, pregnant teenagers and ethnic minority/refugees often featuring strongly. Health promotion strategies again feature strongly as a major determinant of local public health priorities, however, the data demonstrate more diversity and local sensitivity, for example, sun safety, cardiac rehabilitation, and educating carers of elderly are often cited and reflected a knowledge of population needs and priorities.

4.4.3. Key Functions of the Public Health Nursing Role

- Health needs assessment
- Health promotion
- Service and policy development

There was agreement by health authorities and trusts in all regions on the key functions of the public health nursing role. Respondents were also asked about specific functions in relation to each of the specialist areas:

Specific Functions of the Public Health Nursing Role for Practice Nursing

- Health Promotion/disease prevention
- Disease monitoring and screening

For Practice Nursing the functions are described mainly in terms of meeting the needs of the practice population in the surgery setting.

Specific Functions of Public Health Nursing Role for District Nursing

- Health promotion/disease prevention

- Targeted groups (older ages, carers, sick/dying, disabled)
- Health needs assessment

For District Nursing the functions are described mainly in terms of meeting the needs of individuals in their own homes.

Specific Functions of Public Health Nursing Role for Health Visiting

- Health promotion/disease prevention
- Targeted groups (children's health and protection, family/parents)
- Health needs assessment

For Health Visiting the functions are described in terms of meeting the needs of both the practice population and the wider community in surgeries and community settings.

4.4.4. Obstacles and Opportunities in the Work Environment

Obstacles and opportunities in the work environment were also explored for each group.

General Practice Nursing

Obstacles in the Work Environment for General Practice Nursing
- Employers (attitudes, views, control, priorities)
- Poor education and training opportunities
- Lack of resources (time and money)
- Colleagues/Team Functioning (isolation, lack of professional support and rigid boundaries)

Opportunities in the Work Environment for General Practice Nursing
- Access to population (defined population with ability for opportunistic contact)
- Primary Health Care Team membership

District Nursing

Obstacles in the Work Environment for District Nursing
- Competing priorities/views/expectations (traditional views of service and medical priorities and control, especially with fund-holding)
- Lack of resources (heavy workloads and shortage of both time and money)

Opportunities in the Work Environment for District Nursing
- Collaborative working (main emphasis with Primary Health Care Teams, but also interagency)
- Organisation of care (home visiting)

Health Visiting

Obstacles in the Work Environment for Health Visiting

- Competing priorities/views/expectations (traditional views of service, medical priorities with little value on prevention and lack of understanding by others, caseload demands)
- Lack of resources (heavy workloads and shortage of both time and money)
- Organisation of care (attachment to GP practices)

4.4.5. Opportunities in the Work Environment for Health Visiting

There was a very diverse response for this group - for example the changing political agenda was the top strong theme in one region

- Collaborative working (The respondents' main emphasis was on interagency working, but also with Primary Health Care Teams).
- Access to the well population through the universality of the service in visiting all families.
- Knowledge and skills (for 3 of the 5 regions this theme ranked at the top) (responses indicated that health visitors were well trained for public health, had expertise in profiling needs, and had community knowledge).

4.4.6. Contribution of Community Specialist Nurses to Public Health

Responses to this question were generally very poor in terms of detail, though almost all respondents made some comment. There were three main themes:

- Health Needs Assessment
  Responses concerned profiling (caseloads, practices, localities, schools and practitioner knowledge of needs)

- Strategic Planning
  Responses discussed contribution to strategies, plans and reviews (through specific strategic groups, business planning, developing service specifications and locality groups) No or little involvement was also a strong theme in two regions.

- Contracting
  Most respondents highlighted no role or a small role. However, respondents in one region highlighted the contracting role very strongly through management and professional leaders

- Additional Areas of Contribution
  Responses from some districts suggested that people felt under-utilised or had made no contribution to public health work. Data indicated that Health Authorities had not valued nursing knowledge or even had an interest in community health

Opportunities to Influence Commissioning

- Health needs assessment (providing evidence from practice, identification of gaps and assessing community needs)
- Collaborative working (both multi-agency and multidisciplinary)

Public Health Nursing Posts

- Specialists (for example TB nurses, AIDs specialists, accident prevention health visitors, infection control and communicable disease nurses mainly, but a large range of posts mentioned)
- Community nursing (mainly in terms of health visiting and school nursing, although district nursing was mentioned)

Projects which Promote Public Health

- Prevention focus (accidents and heart disease)
- Targeted population focus (parents and children, pregnant women, ethnic groups)

Barriers to Public Health Nursing

Barriers to public health nursing were seen as diverse. Four key areas emerged:

- Attitudes and perceptions (lack of recognition of public health role)
- Education and training (lack of understanding of role for example by purchasers, and lack of training for practitioners)
- Lack of resources (lack of time, money and practitioners)
- Contracting issues(fund-holding, short termism, caseloads, contract process)

What helps Public Health Nursing?

Factors facilitating public health nursing were also seen as diverse. Again four areas dominated the responses:

- Education and training (more emphasis on multi-disciplinary training)
- Resources (more funding generally, which is secure and long term)
- Strategic/Policy Guidance (with clear aims and objectives)
- Collaboration (multi-agency and multi-professional)

Examples of Public Health Nursing

There was a poor response generally to this question, perhaps because many specific posts and projects had already been described. The responses which existed took a strategic focus, mentioning nurses being invited to contribute to strategy development.

Audit, Research, Outcomes and Evaluation in Public Health Nursing

Few respondents completed this question. Amongst those who did, audits were mentioned in relation to:

- Targeted groups (for example children)
- Health promotion/prevention focus (accidents)
- Specific disciplines
- Patient/client focused (satisfaction with services)

In relation to research, there was a very poor response, and no common theme. Identifiable examples included work on leg ulcers, falls in the elderly, and health of the nation targets but some responses also commented that they were not aware of any research.

Looking at work to develop outcomes, again there was a very poor response, and no common theme. Examples noted included work on discharge planning, cardiac rehabilitation, childhood accidents, parenting programmes, quality of life outcomes and a number of respondents who were not aware of any.

A similar response was the case for evaluation. Examples listed included a patient satisfaction survey, an audit evaluation, evaluations of breast feeding and clinical supervision.

4.5. Comparing Findings from Strand One and Two

Generally, the findings in the Trust and Health Authority responses were easier to determine in terms of common themes as there was less diversity in the data than in the Educationalists' responses. Whilst the Educationalists were asked primarily about the educational programmes they delivered, the Trust and Health Authority respondents were asked to focus more on public health in practice. However, responses in two areas could be appropriately compared.

4.5.1. Major Priorities for Public Health Nursing

Trusts and Health Authorities mainly determined their public health priorities through the targeting of particular groups, for example children and families. However, Educationalists targeted their public health priorities in terms of poverty and inequity.

Educationalists	**Trusts / Health authorities**
Poverty/Inequity	National government guidance
Commissioning services and policy development	Targeting of specific groups (eg children and families)
Health promotion	Health promotion

The educationalists had a broader range of influences on how they determined public health, they used international, as well as national literature and appeared to be more greatly influenced by professional and educational literature than those working in Trust and Health Authority environments.

4.5.2. Key Functions of Public Health Nursing Role

There was agreement across a majority of respondents in both groups that health needs assessment was a key function of the public health nursing role. This was cited by more than two-thirds of respondents in both groups. There was also agreement that health promotion was a key function, with a majority of respondents in each group mentioning this.

Educationalists	Trust / Health Authority
Health needs assessment	Health needs assessment
Health promotion/ prevention	Health promotion
Community involvement and empowerment	Service and policy development
Collaboration	

4.6 Summary

This chapter has set out the methods and findings of Strand One and Strand Two of the study. Strand one was a questionnaire based survey of course programme directors and route module leaders from community specialist programmes. The response rate ranged from 29% for Course Programme Directors to 44% overall for Route Module Leaders. The main priority for educationalists was about targeting poverty and inequity in terms of employment, housing, education and health care provision. Health promotion was a strong common theme for all but the route module leaders for district nursing. Programme strengths were identified as rooted in shared learning through inter-professional collaboration and good clinical links with community practitioners and community practice teachers. However, the main weaknesses identified appeared to be around the problems of integrating theory and practice. Shortage of time to deliver the programme adequately was seen as adding to this difficulty. National policy documents featured most strongly as influencing preparation, however, a range of literature from professional and educational bodies was also mentioned. The strongest identifiable public health function across all disciplines was health needs assessment. However, between the disciplines there was great variation.

Strand Two collected the views of senior nurses in each Health Authority and Trust in England about public health work in community specialist nursing. The response rates across Regions ranged from excellent at 64% to extremely poor at 23%. The data mainly reflects the views of senior nurses working in Trust environments. The major influence in determining public health priorities was seen as the information and direction received through national documentation. Local priorities were often

determined through targeting of specific groups, pregnant teenagers and ethnic minorities or refugees often featuring strongly. The key functions of the public health nursing role were seen as health needs assessment, health promotion and service and policy development. Obstacles and opportunities in the work environment were also explored for each group. Public health posts in practice were identified as including both specialist posts (for example TB nurses, AIDs specialists, accident prevention health visitors, infection control and communicable disease nurses mainly, but a large range of posts mentioned) and 'community nursing' posts (mainly described in terms of health visiting and school nursing, although district nursing was mentioned). Education and resource availability featured as both barriers (if lacking) and facilitators to achieving successful public health nursing work.

CHAPTER FIVE

5. LEARNING PUBLIC HEALTH: CASE STUDIES

This chapter describes the way in which Strand Three was carried out, and sets out the detailed findings from the four case study sites. Sampling and data collection methods used are described, and the timescale of data collection set out. Results are then set out for each site in a similar way, using the educational process as a broad framework for presentation. The findings are set out first for the site at which all three disciplines were studied, then for sites at which individual courses delivering district nursing, practice nursing and health visiting specialist programmes were studied.

5.1. Strand Three

5.1.1. Purpose

Strand Three was aimed at tracing the process by which education about public health is designed, delivered and utilised (or not) in each of the three areas of practice, as well as the factors which presented problems at each stage.

5.1.2. Piloting

Piloting in Strand Three began in Spring 1998 and was again undertaken with the help of two sites. This included in depth work with key players in public health, and was thus undertaken with students, practitioners, lecturers and professional leads in trust and health authority environments. It included piloting of both individual and group interview schedules with identified key players and also led to the further development of a reflective incidents tool and a public health key contact diagram. The piloting was completed by June 1998.

5.1.3. Design and Sampling

The results of the first strand were used to inform the sampling for Strand Three. Four areas were selected purposively using a sampling matrix to provide snapshots of different programmes and environments.

The sample at each site included educationalists (Lecturers and Community Practice Teachers), newly qualified practitioners and students and key trust and health authority personnel. In addition, data was gathered using public health incident logs and lists of key contacts /collaborators as well as secondary data such as curricula and policy documents.

5.1.4. Sampling Matrix for Case Studies

During January 1998 a sampling matrix (see Appendix 6) was developed to identify the four case study sites. This was used to review each of the Strand One educationalists responses in relation to their priorities for public health, the perceived

strengths and weaknesses of each course, views on the key public health functions for each discipline, the range of teachers used in the educational setting, obstacles encountered in the practice setting and the general comments of the researcher reviewing. Comments were made in particular on the perceived level of innovation and the apparent breadth of course. Though most of the data used was from full written questionnaires, shortened postal and telephone questionnaires were also used. Each questionnaire was assigned a score for items from the above framework - for example where a respondent had mentioned one of the 'top five' priorities for public health, they would score one. Members of the research team then met and entered scores for each site into a grid, linking strengths and weaknesses for each site and highlighting the reasoning behind each score. Information was also given about specific sites which were thought to be unusual, for example a four year integrated programme, which needed further consideration. Four potential case study sites were highlighted, with the team remaining blind to locations. Course programme directors responses were not used in the sampling exercise as the route module leaders responses appeared to offer a more detailed perspective.

One unified multi-disciplinary case study site was chosen to enable researchers to access the nature of the dynamics within and between the educational establishment, trust, health authority environments, primary health care and other agencies, whilst also following through the learners' experiences from student to practitioner and between disciplines. The other three sites were chosen to highlight specific specialist practitioner disciplines of health visiting, district nursing and practice nursing independently and enable their examination in more depth.

The four sites were identified and back-up sites (second choice sites) also determined.

5.1.5. Recruitment Problems

Access to case study sites began in summer 1998. Almost immediately problems arose. In particular:

- The summer holidays led to a delay in being able to access the sites through the educational systems.
- Through talking to the Universities we realised that some of the responses we had obtained were based upon lecturers opinions about the future integration and validation of their courses and not their current experience, therefore the sites could not be used.
- One site which was approached had few, if any students sponsored by Trusts, making links to practice almost impossible to follow.
- Some sites had only had the course validated for one year and therefore had not been running long enough to have any past students to interview, therefore were discarded.

The choice of sites was therefore more limited than previously imagined. The above issues led to a delay in accessing and successfully recruiting the sites. The following section gives more detail as to what actually happened for each site originally chosen.

5.1.6. Access to Multidisciplinary Site

Site - 32

First Visit

The initial site was contacted and agreed to take part. However, we had to cancel a planned visit on 21st July, since we received no positive responses, only four negatives. We were informed that the last years qualifiers had a review day for 22nd September. Focus groups were organised therefore around that day. Focus groups initially had a very poor response from one year qualified practitioners and just qualified practitioners (n=2) to attend at lunch time. There proved to be no General Practice Nursing students for the year ending 1998. A research team member attended the review of one year qualifiers with their course programme director and route leaders, and used this opportunity to find out why the response rate was so poor. She encouraged four more practitioners to join the focus group. Contact was made with one of the community trust professional leaders, who agreed to support the research in her Trust. This experience informed our recruiting approach to other sites.

Second Visit

Our second visit took place in November 1998. Focus groups were arranged with newly qualified practitioners, one year qualified practitioners, and community practice teachers. Choices were given of lunch time and evening attendance. Individual interviews were also arranged with professional leads, lecturers, commissioners and public health specialists within trust and health authority environments.

5.1.7. Access to Health Visiting Site

First Chosen Site - 20

The initial site for health visiting was contacted and agreed. It was planned to hold a Focus Group on 22nd July, 1998. This was cancelled and rearranged for the 3rd August due to time shortage and administrative problems - for example, personal details could not be given out to the team and therefore every formal individual contact with practitioners had to made through the educational establishment. However, this was subsequently cancelled following more in depth discussion with the route module leader. Students at this site were not usually sponsored by trusts, most were independently funded, therefore working in multiple Trusts across the UK. Students also emerged from the course dually qualified, usually with a district nurse and a health visitor qualification, which was atypical. This site was therefore excluded from Strand Three.

Second Chosen Site - 19

This site had been selected as a back up, based upon a telephone response when following up those route module leaders who had not completed original

questionnaires. However, it proved impossible to access students at this site, due to problems in obtaining the Dean's clearance.

Third Chosen Site - 28

A further back up site was selected blind by the research team. A positive response was obtained at this site. Data collection took place in February 1999.

5.1.8. Access to General Practice Nursing Site

First Chosen Site - 5

We were not able to use this site, as the new integrated course did not start until September 1998.

Second Chosen Site - 17

We were not able to use this site, as the new integrated course did not start until September 1998.

Third Chosen Site – 7

A further back up site was selected blind by the research team. No positive response was obtained from staff at this site.

Fourth Chosen Site - 15

Yet another back up site was selected by the research team. At this site a positive response was obtained and key contact details were received. Data collection took place in December 1998.

5.1.9. Access to District Nurses

Chosen Site - 12

The initial site was contacted and agreed. However, difficulty was experienced in taking the research forward as staff at this site did not initially send the key contacts list which was vital to accessing key personnel outside the educational establishment. Data collection took place in January 1999.

5.1.10. Issues in Relation to Sampling and Interpretation

The difficulties in obtaining a viable sample described above raise issues in relation to the interpretation of the results. In most cases, initial access was difficult because of local organisational issues, but for general practice nursing, two sites which were approached had completed the initial questionnaire in relation to a course which was not yet running. The team were also concerned that some respondents seemed to blur boundaries between earlier related courses and the community specialist programmes.

This could perhaps be expected, but makes exploration of the relationship between a specific course and its outcomes more difficult. Though participation rates within each site were lower than hoped for (see Appendix Two) the impact of this appears likely to be firstly in the potential bias introduced by the process of opting in - were these respondents the most highly motivated towards public health work, and can they therefore be seen as representative in any sense of the less motivated? We have no clear evidence on this point. Secondly, there may be an impact in the range of concepts which can be uncovered - which is likely to be more limited with a reduced sample size. Thirdly, with a restricted number of participants, there are limitations on the depth of analysis which can be achieved. However, at most sites all planned groups were represented within the sample, so that exploration of issues and ideas from different perspectives could act as a partial compensation.

5.1.11. Data Collection

The following four data collection sites were eventually identified and permission was granted via the relevant University to engage the site:

Case Site Number	Ranges of Specialist Practitioners
32	District Nursing Health Visiting Practice Nursing
15	Practice Nursing
12	District Nursing
28	Health Visiting

This strand involved in depth data gathering at four locations which presented different challenges and opportunities for public health work. We planned to interview the people preparing community specialist practitioners at each location, to find out how their courses operated. We intended to use focus groups with students completing the relevant courses to find out how they saw public health work, and what they saw as barriers or enabling factors to them adopting public health roles. We also sought to hold focus groups with practitioners who had graduated from the same courses in the past year, to collect examples of current public health practice, to find out how they see public health work, and to determine what, with the benefit of experience, they saw as barriers or enabling factors to them adopting such roles. Students and practitioners were asked to complete reflective public health incident logs. Finally, we planned to interview key health service colleagues including trust managers, nursing colleagues, GPs, commissioning managers and directors of public health, in order to discover how they viewed current public health practice and what they saw as the strengths and weaknesses of their local environment for public health practice.

Analysis was intended to enable us to look at how preparation for public health work translated into practice, and the factors which appeared to obstruct or enable practitioners to adopt effective public health roles. Figure 2 summarises the case

study process and links data collection to the questions which we are asking at each stage.

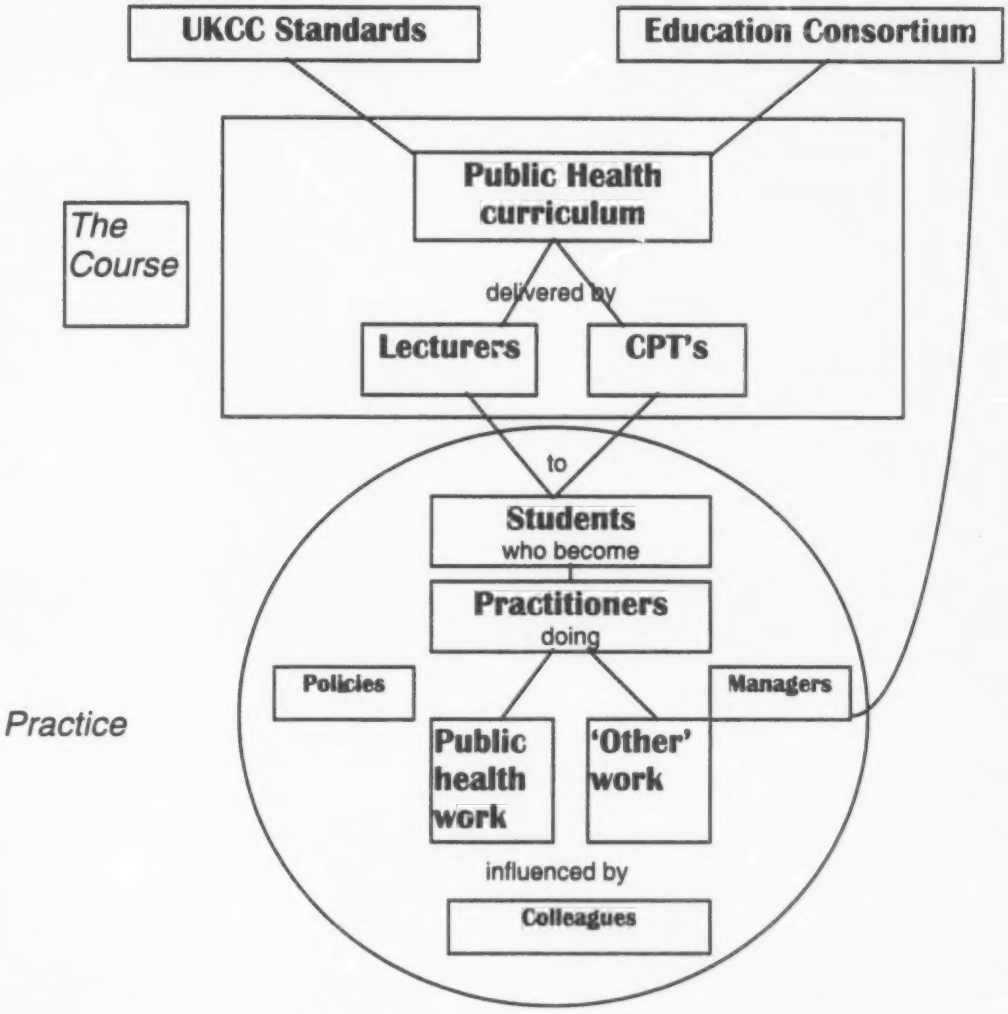

Figure 2 The Educational Process Influencing Public Health Practice

1. What is the intended curriculum content in relation to public health?
2. What public health teaching is delivered?
3. What factors influence learning about public health?
4. What public health work is actually carried out by practitioners who have received this preparation?
5. What other factors influence public health work?

87

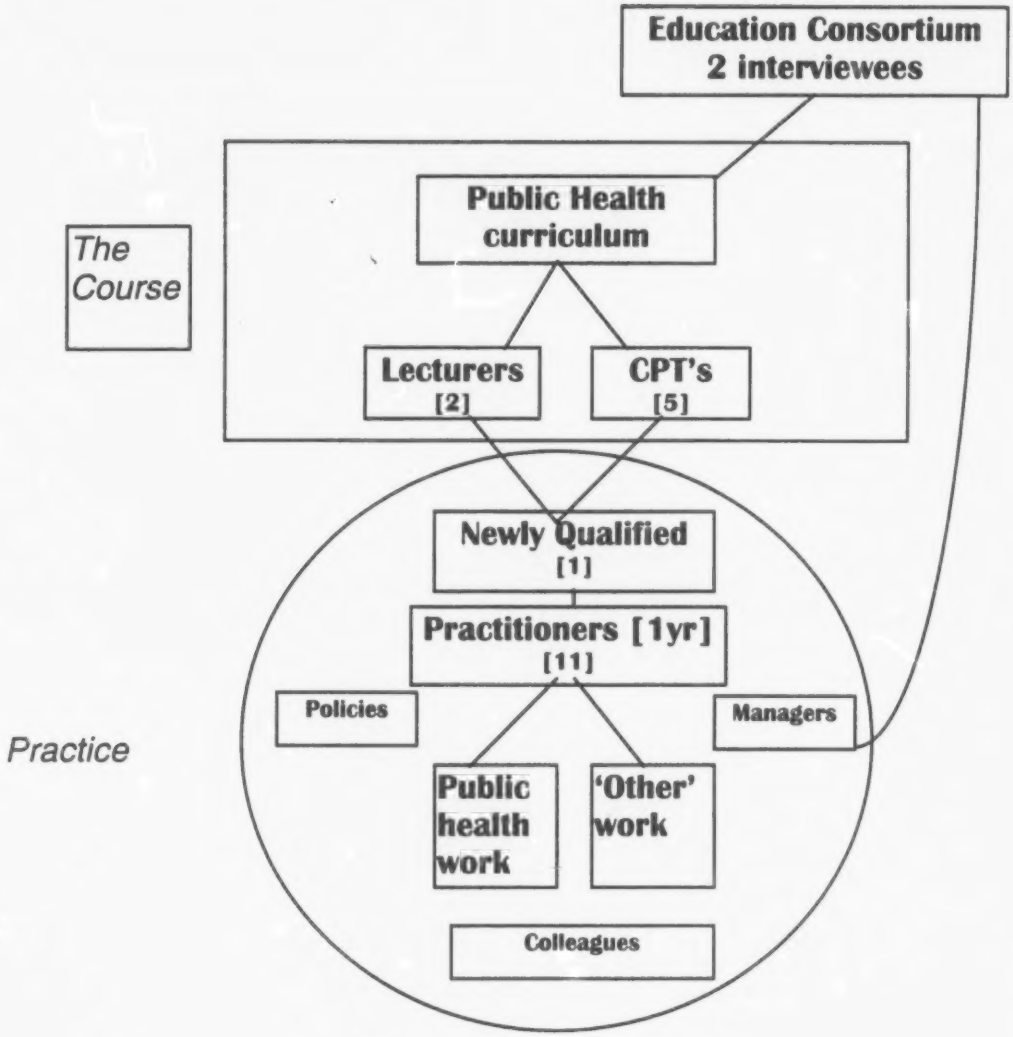

Figure 3 Site 32 - Data Sources (See Appendix 2 for numbers & roles of interviewees)

5.2. Case-Study Site 32 (Multidisciplinary)

Central to this study was the evaluation of the effectiveness of the key learning outcomes for three specialist community practitioner (SCP) programmes (including health visiting, district nursing and practice nursing) as demonstrated in practice. These data were collected from several sources including semi-structured interviews, curriculum documentation, postal questionnaires to the Regional Health Authorities and Trusts and logs of critical incidents described by practitioners. The interviews in particular explored a variety of representative stakeholders concepts of public health, health promotion and primary care; including implementation issues. Views were sought specifically in relation to the courses' preparation of SCP's for the public health role.

5.2.1. The Context

This case-site is characterised by a diverse demographic range and subsequently population health needs. Whilst it is situated within a largely very affluent county in the South of England, it also serves two urban areas with the highest deprivation scores in the county. These urban areas include a mixed, multi-ethnic population, incorporating people from the Indian sub-continent and the Caribbean. Whilst rates of coronary heart disease and diabetes match the national average for these groups, these are in any case higher than those of white populations. A specialist health visitor allocated to the care of the homeless works in one of these urban areas, whose caseload includes a relatively large refugee population and resulting health needs, for example high rates of TB.

The contrasting affluence and deprivation particularly highlights the notion of relative deprivation in the rural areas of this county. It is illustrated by a number of people in the affluent rural areas with housing tied to their relatively poorly paid work, resulting in problems with transport and thus access to health services for some of this population. The local Health Improvement Plan specifically targets teenage pregnancy and coronary heart disease. There are however well established community hospitals that serve the smaller towns of the county.

During data collection, a service review for health visiting and school nursing was in progress and representatives from the public health department declined to participate in this project. Unfortunately therefore, this case-study site does not incorporate any of the views of that department.

This project aims to focus on health visiting, district nursing and practice nursing and this case-site explored the inter-relationships and issues from this multi-disciplinary perspective. However, whilst practitioners from each of the three disciplines are represented, the course leaders backgrounds were in district nursing and health visiting; there was no educational representative from practice nursing. Equally, the project team were unable to engage any of the existing practice nurse assessors (n = 4) in the study. The weight of evidence supporting the practice nurse data is therefore weaker than for either health visiting or district nursing.

5.2.2. Findings

It is not the purpose of this study to seek definitions of public health per se. However in order to evaluate the effectiveness of the SCP's application of public health theory and knowledge into practice, it is important to understand participants conceptualisations of public health. Route module (RML) and course leaders will influence both the content and delivery of the programme to the students. Whilst the interviewees constituted a mix of genders, for the sake of simplicity they will all be referred to as 'she'.

The CPT's and assessors of supervised practice hold a pivotal role in the teaching, facilitation, assessment and supervision of community nursing students. The CPT's understanding of the nature of public health will therefore impact fundamentally upon the opportunities they shape and provide for students. Within the present context, the role involves enabling the student to achieve key learning outcomes that relate to public health practice.

In order to meet this study's primary objective, the educational preparation of SCP's for public health practice has of course been explored. However this alone is not enough to determine whether the aim of '*effectiveness as demonstrated in practice*' has been achieved and to explore the '*developmental implications for the role of specialist practitioner in the context of public health*'. Stakeholders in the Trusts and Health Authorities, for example professional leads, managers and educational commissioners, exert a powerful influence upon the context within which these nurses practice. Thus these organisations (and the representatives working for them) exerted considerable influence over whether practitioners were enabled or obstructed in developing a public health role that contributed towards a nursing public health approach. Their contribution towards both the commissioning of education to prepare nurses for the public health role and the context in which these nurses practised, was therefore also examined.

Developing some clarity about the meaning of public health and how such an approach may be implemented is crucial if the specialist practitioner role is to produce an effective public health nurse.

5.2.3. Theme 1: Concepts and Perceptions of Public Health Practice

Whilst a disease prevention model featured to greater or lesser extents within the data of all three nursing disciplines, the images of public health that they expressed were largely not bio-medically grounded. Conceptualisations of public health derived from the social determinants of health, these practitioners made connections between the social and contextual issues.

Practitioners from the three disciplines expressed ideas and images of public health that reflected their own discrete areas of practice. For example the health visitors as a group largely expressed their public health images with a population or community focus. This corresponded with the delivery of public health education by the route leader for the health visiting module who aspired to approach the notion of presenting a public health agenda from a social and collective perspective by developing health visitors [RML.HV] *"critical insights into social relationships that shape peoples health...particularly around the development of alliances and partnerships"*.

In contrast, the practice nurses offered examples which reflected their work with individual patients and clients who accessed their services within the General Practice. The boundaries surrounding practice nurses' conceptualisation of public health, health promotion and primary health care were blurred, [FG.PN]*"if you're thinking of health promotion, which is how I perceive it* [public health], *that's health promotion work I think in General Practice"*. In other words they operationalised notions of public health within a health promotion framework that was delivered in clinic settings, *"healthy hearts, well-women and men's health checks"* enabling them to rationalise the pro-active, public health elements of their work within the contextual constraints of their role in the surgery.

District nurses also conceptualised their images of public health as individual work but in contrast to the other two disciplines, they were framed within a model of illness prevention rather than health promotion. However, whilst an illness perspective underpinned the district nurses examples of public health (including newly qualified practitioners and CPT's), there was evidence that they did understand the implications and inter-connected issues impacting upon collaboration, resources and the political agendas that exerted a wider influence on the public's health.

Despite evidence of different approaches to public health work between the three disciplines, without exception they all struggled to express their meanings of public health. Some demonstrated more ability to do so than others, however the crucial point was this; they all experienced considerable difficulty in articulating real examples of it within day to day practice. This suggests that whilst these practitioners were able to articulate some ideas and notions of public health as an abstract concept, they failed to integrate this into the reality of their practice. Thus a key message from the data suggests that practitioners espouse public health as important, but that 'someone' was doing public health elsewhere as a discrete entity; it was not a notion synthesised into everyday nursing practice.

The SNMAC report (DoH 1995) identifies the nursing contribution to public health. A *focus on health promotion, combined with disease prevention* is one element. Indeed, this notion that the community nursing contribution to public health was grounded within a health promotion model emerged strongly from the interview data. This was translated in the University's curriculum documentation, as health promotion which features strongly, however there were distinctive differences between the three disciplines. District nursing focused on the three dimensions of health promotion, *distinguish primary, secondary and tertiary modes of intervention used to promote health and prevent illness,* whilst the objective for practice nurses aimed to *evaluate the use of health promotion models* in addition to *changing clients health behaviours and illness outcomes.* Health needs assessment, and working with clients to identify their health needs were incorporated within the health visiting role, aiming to develop practitioners who *proactively address public health issues.*

In contrast to practitioners, the two lecturers, one who had a background in health visiting and the other in district nursing, demonstrated little difficulty in expressing their images of public health, contextualising it within a broad-based, community model that conceptualised structures and frameworks by which the public's health could be improved. Nevertheless, they also experienced difficulty in providing practical examples of public health and in identifying any local public health initiatives. Rather, they, like practitioners, operationalised public health for

community nursing within a health promotion framework and in terms of data collection, interpretation and application.

Whilst educationalists strove to deliver public health in ways that students could apply it, implementing a public health agenda within the context of day to day community nursing practice, the complexity and enormity of the task was perceived to be profound. For example, the GP Practice/PHCT model of health care delivery, focusing on a micro population, was perceived to be a major barrier to implementing a public health strategy. The concept of the primary health care team (PHCT) was perceived by many practitioners as a reactive model of dealing with health needs. In contrast, working in the community environment was perceived to facilitate a broader, more proactive approach, [FG1.PN1] *"I think maybe we should be moving outside of surgeries and getting in to the community more"*. However even if they were taking a community perspective, what they could achieve as nurses continued to be problematic, [FG1.PN2, in response to above] *" Yes but what could we actually do when we got there* [in the community]*?"* This response also serves to illustrate the emphasis and relative importance nurses place upon the most visible aspects of work ; that of doing things. In contrast less tangible or visible work may be perceived as also less legitimate and important.

Educationalists viewed images of public health, health promotion, and primary care as different entities, albeit overlapping. Whilst recognising the inter-connections differences between the concepts were identified.

[RML.DN] "...[primary health care is] *different from public health, although I feel that public health and primary care are interconnected... health promotion on a wider level"*.

The delivery of public health education within the course curriculum was influenced by the professional background of the route leader; matching their educational role as route leader for district nursing or health visiting. The route leader's function included facilitating the development of practitioners' knowledge and expertise that were transferable into skills they needed to expand and implement public health work within practice. Whilst measures were taken to enable students to make connections between public health theory and practice, the barriers that impinged upon the process were evident to the educationalists.

The UKCC's standards [Appendix1] for community nursing education and practice common core learning outcomes are explicit in this curriculum documentation. They included, *'identify the social, political and economic factors which influence patient/client care and impact on health'*. In fact a broader picture of delivering a public health nursing approach was threaded throughout learning outcomes of the common core, not surprisingly however, it was emphasised within the public health nursing/health visiting specialist route.

Educationalists sought to explicate links between public health, the individual patient and communities. The evidence from these data supports the view that practitioners have a theoretical grasp of these influences on public health. However, the problem remained that whilst formal teaching of public health was delivered, this in itself may not have changed practitioners attitudes, and thus service provision, to the application of a broader perspective to every day practice:

[RMLDN]*"I remember a district nurse saying, I really found those social policy lectures interesting, but I don't really know what it had to do with district nursing"*. Thus the gap between theoretical knowledge and grass-roots practice may continue unfilled, suggesting that the theory may have been digested by the students but only in an abstract sense; this knowledge is not translated into skills and practice.

To summarise then, within the interview data, .educationalists, experienced CPT's and newly qualified practitioners alike all struggled to articulate actual examples of public health. This was in contrast to findings emerging from the critical incident logs [CI logs].

5.2.4. Theme 2: Public Health in Practice (Hurdles and Levers)

Whilst the interview data yielded few clear descriptions of the concepts of public health and even fewer examples of public health practice, practitioners written descriptions provide some evidence of a rather different representation. The strongest theme that arose from these albeit limited data identified that practitioners had clear ideas of the interventions they needed to implement if they were to promote public health (n=5:- 3 health visitor CPT's; 1 district nurse CPT; 1 newly qualified health visitor). In other words whilst they may have had difficulty in articulating their abstracted notions within an interview, they were unambiguous about the work that they needed to undertake if they were to achieve this objective. However, without exception they were unable to implement these ideas, usually due to structural constraints.

The health visiting and district nursing position, perhaps unsurprisingly, differed only in one respect; the district nurse expressed her views from an individual patient perspective whilst the health visitors approached it from a broader, collective position. The individual perspective reflected in the district nurses response, was characterised by the inherent conflict between imposing professional knowledge that clashed with patient's own preferences and values. This was compounded with the enormity of trying to fundamentally improve the patients care in certain poor housing conditions, [CI logs DN]*"experienced difficulties in organising home visit by occupational therapist...social services unable to gain permission to attend to remedial home repairs and cleaning...whilst respecting a clients wishes, this presents an impossible task for health carers as without improved living conditions, problems with encouraging healthy independence."* Whilst public health work may seem a desirable notion to professionals, patients and clients may hold a different view of their quality of life and health needs.

The health visitors proposed to target specific groups with identified health needs, [CI logs HV] *"families in temporary housing; isolated families without transport; parenting support groups; women's health groups."* The district nurse expressed ideas for changing systems and the context of care, but used individual patients as examples.

The common thread throughout all these individual examples may be summarised thus. Practitioners were able to identify pressing public health needs in their own communities and develop a plan of care to address the issues but ultimately they were constrained by barriers beyond their individual control. Furthermore, practitioners believed that their innovative ideas were unsupported by managers and colleagues from other disciplines. Thus these projects were only sustainable by the sheer

determination of the individual; [CI logs PN]*"disappointed that GP's not more enthusiastic* [building data-base to enable profiling of health needs, targeting smoking, ante-natal parents] *but determined to see it through."*

Practitioners perceived this broader, proactive approach to their work as valuable, it was underlined by positive evaluations from clients. Interestingly this 'add-on' work had been evaluated whilst there was a noticeable lack of references to evaluation, or indeed to the need for it, surrounding 'routine' work. There was nevertheless, an implicit perception that it was seen to be what has been described as 'fringe work' (De la Cuesta 1994) and had to be fitted in around legitimate 'caseload' work. The notion of 'legitimacy' seemed to be linked to the perceived lack of endorsement for this work by Trust managers and medical colleagues. In other words practitioners believed these people did not value public health. If the demands of public health work were seen to impinge upon individually focused caseload work, the caseload would take precedence:

[CI logs HV] " [the women's health groups were] *time consuming and produced more work as these women tended to continue to contact the health visitor - ok at first but as caseloads grew we had to abandon the group."* Equally, practitioners themselves may place lower value on the less tangible, proactive aspects of public health work, than on the immediacy and reactivity of caseload work.

In conjunction, broader principles, such as accessibility and equity, were often missing from the organisations infrastructure:

- The healthcare system itself did not support a broader approach to practice *"need identified by health visitors in the locality, families in temporary housing had greater health needs and were falling outside the system."*
- Resources, including time, managerial endorsement and skills deficits were equally problematic:
  - Time, *"would like to be more involved - no time, a mammoth task!"*
  - Legitimisation of the work, *"support from senior management - eventually!"*
  - Lack of skills/expertise to undertake this work effectively, *"feel inadequate ie local knowledge of housing procedures and solutions to help those in temporary accommodation."*

Further evidence of structural and/or role constraints emerged from the interview data, although each of the three disciplines experienced different and discrete pressures and expectations. The practice nurses perceived the underlying structure of their jobs as different to the community nurses employed by Trusts. Practice nurses were employed directly by GP's and thus special expectations and demands were placed upon them. This could prevent them working from a public health perspective as there was a perception that their GP employers were [FG1 PN 1]*"more interested in tasks and throughput of patients than quality and time"*. [FG1 PN 2 interjects] *"so health promotion and public health might go out the window."*

The district nursing role was subject to it's own conflicts;

[FG1 DN responding to the above two comments] *"I would say that was true as well of district nursing but it is time constraints and how you balance your public health role and the wider community nursing role with our activities counted by face to face contacts. That wasn't addressed on the course."* This illustrates the notion of 'legitimacy' once again; time constraints imposed by reacting to caseload demands

versus a broader public health perspective. In contrast, the health visiting role was perceived to represent the legitimate face of public health nursing. This was despite recent local service reviews and job losses that health visitors felt were particularly effecting themselves.

To summarise then, there appeared to be no shortage of ideas to promote public health but practitioners were unable, for a number of reasons, to translate them into reality. These issues added up to the notion that practitioners were 'working against the tide' when they had identified important gaps that required alternative, collective methods of service delivery. One health visitors' experience summarises these issues. She identified the need to take health care provision into the community itself with a mobile health centre to those people without the means to access transport, however; [CI log HV]*"I felt frustration at not being able to provide the service... constraints come from Trust policies, time and working in a GP practice, lack of resources."*

These themes of structural constraints imposed by being Surgery based were reflected in another health visitors attempts to offer positive parenting workshops to the community, [CI log HV]*"those who have attended, the feedback is positive...I feel the constraints to public health because of working in a GP practice. I would have liked to offer these groups to the whole community rather than just the clients registered with the GP practice."*

Clearly then, however effective the educational establishments preparation of community practitioners for the public health role, powerful structural barriers impact on practitioners eventual capacity to translate public health knowledge into practice.

Education and training consortia directly purchase nurse education in this Region. These bodies influence the content of community nursing courses locally, within the frameworks of national ENB and UKCC learning outcomes for specialist practice. The application of these standards are operationalised locally, within the learning outcomes of the curriculum documentation.

Thus a clear understanding of public health as a concept, and knowledge of the skills needed to fulfil an effective public health role, may be imperative for these commissioners of education if they are to contribute to the preparation of an effective public health nursing work force. However fundamental uncertainty and a poor understanding of both the context of primary care and the skills that specialist practitioners needed to equip them for undertaking public health practice characterised the data. The senior commissioner had a background in secondary care;

[Commissioner 1] "*coming from an acute Trust background I don't know as much about primary care as I do about secondary care...yes I feel quite constrained because as I say I come from only an acute background and I feel quite frustrated that it's such a complicated and wide subject* [public health] *and that I don't know more about it than I do*". The lack of understanding was also demonstrated by her inability to identify examples of health promotion, public health and primary care; "*I've not come across health promotion in O at all. I'm sure its there somewhere.*" or to differentiate between them, "*I don't see them as de-marked areas. I see them all as part of primary care.*" Furthermore when asked to say something of their own ideas about public health, they were unable to express it as a concept:

[Commissioner 1] "*have you got any ideas what comes to your mind about public health?* [asking colleague in response to interviewers question]."

[Commissioner 2 in response] *"well I would say GP practices, opticians, dentists, an awful lot of pharmacists. I would say those kind of staff groups are generally involved in delivering public health and probably have the highest profile within the public health role in general"*. Thus although public health was conceptualised by occupation, nursing as a discipline was not included by the commissioners.

The commissioners raison d'être was to commission the education that prepared the workforce with the skills necessary for service delivery;

[Commissioner 2] *"we're really charged with providing the education that enables Trusts to develop their workforce in a manner that's most useful to them."* This involved purchasing education that prepared practitioners for the new roles that Trusts were developing, in order to match service needs. It was not perceived as necessary to understand the details of the skills that community nurses needed in order to do this. In summary then, public health as a notion was poorly understood by the commissioners and in any case they perceived such knowledge as falling outside their remit, nor did they see it as even necessary to achieve their aims .

Interestingly, the major barriers to the implementation of public health work that the Trust manager identified, matched the practitioners and CPT's. She believed the first barrier related to the notion of newly qualified practitioners *"looking at their caseloads, getting themselves sorted out, finding their feet...I really can't think that newly qualified practitioners acknowledge public health."* In other words getting familiar with the individual, tangible and reactive work inherent in their caseloads before they were able to undertake a broader public health approach to their work. Across the spectrum a range of participants commented that new practitioners need to begin to feel confident with individually focused, routine work before they could develop the skills to work effectively from a collective, public health perspective.
Experienced colleagues had the potential to act as major barriers to newly qualified practitioners who were trying to work in creative ways. The practice context contained very experienced practitioners who, may continue to work from a traditional, caseload perspective, suggesting that experience may not only act as a facilitator to the undertaking of public health work but may equally present a barrier;

*[*Trust Manager*]"it's very easy to fall in to that way of doing something , especially when you're newly qualified and you've got somebody who's been there a long time and who's very experienced and this is the way we do it here. Its very difficult to stand up and say well actually I'd sooner do it this way...That's why I was saying that the Trust as employers generally, we have to think where we place people."*

Whilst this manager considered the application of public health principles into the daily work of health visitors and district nurses as desirable and espoused the view that the Trust should work on ways to nurture and facilitate this within the current structures, she was equally unable to identify any examples of collective approaches to public health work within the Trust. She believed that students weren't prepared with the skills and knowledge to work in community development, nor was the Trust able to generate managerial and professional changes to support the use of collective approaches. Although she espoused the belief that the advent of Primary Care Groups could facilitate this way of working, this seemed to be based upon the view that PCG's would have multi-agency work on their agenda. However PCG's will be dominated by GP's whom as a profession were not perceived to value public health work:

[CPT HV3]"*I think public health is at the bottom of the pile...it's a low priority within a GP practice.*"

In contrast, the professional nurse lead [PNL] in the Trust had a more strategic perspective and was able to identify and explicate some examples of innovative public health projects, including a variety of nursing disciplines that were involved with individual projects, however, health visitors were represented across all the projects cited. She stated that the projects clearly identified *"the link between public health, health promotion and service provision."*

She was also able to articulate examples of mainstream activities that underpinned a public health approach by a variety of community nurses and whilst not necessarily labelled public health, were characterised by collaborative, cross-agency work with targeted populations, *"collaboration, inter-agency working, morbidity and mortality data, community development work"*. This professional nurse lead demonstrated both an understanding of the nature of public health work and a knowledge of what was actually happening in practice.

The nurse lead's perspective provided a bridge between the university's delivery of the SCP course and the practice context, incorporating the Trusts expectations and perceptions of the final 'product' (the specialist practitioners). She believed that the necessary personal characteristics of the practitioners needed to undertake public health work included *"enthusiasm and commitment"* this was inadequate without a *"management system that would support them in doing these initiatives"*:

[PNL] "... I want to use that year [the first in practice] *to the Trust's and the patients advantage... we're not giving them the fertiliser...and they do need a year to settle down before they can do that* [public health work]."

Thus further recognition that the context into which these students emerged following the course did not necessarily support and nurture the skills that they needed to undertake public health work. A period of time had to pass during which new practitioners consolidated mainstream practice principles before attention could be realistically focussed on public health work.

5.2.5. Theme 3: Teaching Public Health in Practice

CPT's were described by the educationalists and professional lead as the '*bridge*' between education and practice; they were perceived to be key to the success or failure of achieving learning outcomes in student's practice. Therefore CPT's perceptions and approaches to integrating public health work into their own practice must be fundamental to providing the framework by which students will develop their understandings and applications of public health concepts.

CPT's are experienced practitioners; they are perceived thus by students and managers alike, consequently they are crucial role-models for students. Their attitudes and beliefs surrounding the relative importance and significance of public health work may be integrated into the student's value systems, perhaps exerting a more powerful influence than formal education:

[HV1 FG1] *"...there is this balancing act that you hear in college and you might try in practice but then your CPT says, oh well that's what they say but actually we have to do it like this... I think you are influenced a lot by the CPT, because you put them on a pedestal and see them as someone very knowledgeable, they do it every day,*

where someone from college comes in for a couple of slots that week." Whilst the students perceived the CPT's as a key influence on their practice, the CPT's themselves perceived the academic work-load as a barrier that impinged upon the community nurses exposure to practice:

[CPT HV2] "...they need to concentrate on practice in the last ten weeks...they have to finish a great big assignment and that detracts completely until that's done...I do think the academic course work does impinge on the practice placement."

Newly qualified practitioners, CPT's and educationalists alike, struggled to express how they fitted the public health component of the educational programme into the every day realities of practice. There were implicit differences between district nursing and health visiting roles and the delivery of health care, the barriers that each discipline encountered derived from different sources. Despite the differences, both health visitors and district nurses operationalise the concept of public health by constructing it within a health promotion framework.

It is perhaps significant then, that the overarching theme arising from the district nurse CPT's was the tension between their roles, dictated by the structures within practice, and the organisation by whom they were employed. They believed that this contrasted with the health visiting role, which was perceived as fundamentally public health or health promotion orientated. Service delivery for district nurses focused on working with individuals, (DNCPT1) *"I think their main work* [district nurses] *is really visiting sick patients."*. This implicitly individualistic role focusing almost entirely upon the management and care of illness or disease was not perceived to fit easily with a broader, preventative approach to promoting the public's health. However, whilst the other disciplines perceived that health visiting represented a public health perspective, in contrast the health visitors themselves believed that they were driven by contractual and statutory requirements, for example visiting new births and children's developmental assessments, which are individually focused.

The preparation of safe and competent practitioners required that the health visitor CPT's equipped the students with negotiation skills, cultural awareness, good communication skills, effective interpersonal skills, empowerment, management of groups, networking and interagency liaison skills, searching for information, assessment skills. These were perceived as fundamental tools that prepared the students with a foundation for practice. In contrast to this there was a belief that the skills of the students were somehow acquired naturally and could not be taught by the CPT's, thus they would find it difficult to implement competent public health practice, [CPT HV1] *"...they find it difficult, some people are not very assertive and perhaps they feel for the public health role you have to be very assertive and have a voice that will be heard."* Practitioners may claim the role of an empowering patient advocate, but they need to be empowered themselves if this is to be effective and students may not be an intrinsically empowered group.

The main barrier, identified by the health visitor CPT's, to teaching public health work was a notion that may be described as the 'unpreparedness of the direct entrant'. This is peculiar to the health visiting students who are virtually always new to this discipline, in contrast to other practitioners on the SCP course. When the students begin the course they have little conception of what health visiting is really about; in contrast, the district nurses have often been working in the community and practice nurses have also been working in the practice nurse role:

[FG2 CPT] "*for health visitors* [students] *they don't really have an awareness of the full role of health visiting which encompasses public health.*" The newly qualified practitioners themselves also recognised and expressed this within a mixed discipline focus group:

[FG1 PN] "I think the health visitors were at a disadvantage because they were one of the only groups that came in with very little previous knowledge of the job...practice nurse, left practice and came to do the course and went back to practice, district nurses might have had some sort of experience in district nursing before they came."

Linked to this theme of 'unpreparedness' was another barrier to teaching public health, conceptualised as 'getting students through the course'. This was characterised as the means by which inexperienced students passed through the course, with the support of the CPT, and emerged as a practitioner. However, the process was not complete for some considerable time; the newly qualified practitioner needed to consolidate the course with practice. This was fundamental to all disciplines in relation to implementing public health work, but of particular concern for the health visitors due to their 'newness' to the primary care context (many were believed to have entered health visitor training directly from posts in secondary care).

The health visitor CPT's perceived their fundamental role here as essentially "*supportive*" in essence. They believed that these barriers only enabled them to deliver a "*foundation*" which prepared the students for "*competent and safe practice.*" In other words they have a lot to cover in the forty week course, which is really just an foundation for practice, experienced practice could only be developed after the course;

[CPTHV3] "*all you're doing is sowing the seeds of what they could do when they get out there with their own workload, drawing their attention to the possibilities that they could become involved in.*" There was a perception that the students were more than capable of acquiring the knowledge during the course, however the skills were somewhat more difficult to develop. In other words, the students were capable of learning the theory that underpinned practice, however time and experience in the field were necessary before they were able to convert this knowledge into skilful application.

Achieving any meaningful synthesis of public health and health promotion knowledge during the course was perceived as unrealistic, as students (and indeed newly qualified practitioners) needed more experience before they were able to integrate the less tangible notions, inherent within public health work, into their everyday practice.

This however does not match the UKCC's definition of a specialist community practitioner which proposes that pre-registration education provides practitioners with the knowledge, skills and attitudes to deliver safe and effective practice. Additional education is required if practitioners are to exercise higher levels of judgement and discretion to function as specialists. In other words this preparation for specialist community practice is perceived, by stakeholders and specialist practitioners themselves, as preparation for the safe and effective delivery of public health work. Therefore the expectation that practitioners will be exercising higher levels of judgement and discretion, with public health, and even in generic practice on completion of the programme, may be unrealistic.

Despite the assumption that health visitor knowledge for public health practice will come with further experience, it was interesting to note that the CPT's themselves encountered considerable difficulty in articulating examples of public health initiatives within their considerably experienced practice. They were however, able to do so in the critical incident logs.

The intrinsic limitations imposed by the practitioners relative inexperience on entry to the course and the ensuing time constraints imposed by the course, converged. This was compounded by the environment within which they worked and the resources that were available to support public health work. The constraints of reacting to individual social problems and case-load demands could be overwhelming. It was also interesting to note that they believed barriers could be imposed by colleagues and the existing structures and culture of that workplace. This concurs with much of the emerging data from the educationalists and nurse-lead interviews. The general perception from these interviewees was that assertiveness skills and developing a flexible, critical thinker with a broader political and evidence-based perspective would equip them with the 'tools' and foundation to, eventually, develop innovative public health practices.

5.3. Case Study Site 12 - District Nursing

In common with each of the sites, this case-study examines the effectiveness of the key learning outcomes for the specialist community practitioner programmes, as demonstrated in practice, and explores the developmental implications for specialist practitioners in the context of public health. This particular case-study focuses on the preparation for public health practice of district nurses.

These data were collected from a similar spread of practitioners and stakeholders, as described in each of the case-study sites [see Appendix 2].

5.3.1. The Context

This case-site is primarily urban. Although there are pockets of affluence within the conurbation which the University serves, deprivation is widespread. Mortality and morbidity are high. Particular concerns exist in relation to heart disease and stroke, diabetes, mental health, sexual health, substance misuse, alcohol and oral health. Key areas for action in the Health Authority's Health Improvement Programme also include the environment, unemployment, poverty, housing and transport.

Historically, the economic infrastructure of this area was supported by heavy industry, including ship-building and maritime repairs. However, in common with the global picture, heavy industry has declined during the 1980's, whilst the service industry, with its lower salaries, has burgeoned. For example several call centres have sprung up in the area in recent years. The numbers of inner-city dwellers is declining, in contrast the population in the surrounding rural areas is increasing. Whilst the core population is fairly static, particular health problems are generated by a popular holiday resort in the area, which ensures an additional transient population of 150,000 people during the summer season, presenting seasonal burdens to the health care services.

Relatively high levels of specific health problems, such as sexually transmitted diseases, may be associated with a thriving local sex industry. Nevertheless whilst there are reported increases in Hepatitis B and C, there is no evidence of increased numbers of people with HIV or AIDS. The hepatitis profile may also be linked to the relatively large numbers of the population who inject illegal substances (personal communication, Public Health Department, 1999).

The area is also characterised by high numbers of people with smoking related diseases such as asthma.

The resident population within this Health Authority is approximately 300,000, and is served by three Primary Care Groups (PCG's). Each of the PCG's are characterised by quite specific population groups. One PCG [a] (pop.90,000, registered with a GP) is distinguished by very high levels of deprivation, social problems and a largely young, family-centred community. This population resides within a relatively small, densely populated inner-city area. Very high deprivation indices have ensured that this particular area has been designated as 'Level 1', attracting targeted, 'ear-marked' funding from the European Union's Development Fund. It has also qualified as a Government Health Action Zone.

PCG [b] (pop.73,000) may be described as lower-middle class and middle-class. Whilst PCG [c], (pop.120,000), is spread over a larger, semi-rural area and is characterised by affluence. The demographic age profile of this PCG includes

relatively high numbers of elderly people, reflected in the presence of large numbers of care homes and private, residential accommodation for the elderly.

The ethnic profile of the community as a whole is largely white, European.

Recent population health needs assessments have determined the Health Authorities Health Improvement Programme. Deaths from disease categories include:

- cancers [34%]
- CHD [18%]
- stroke [5%]
- accident [5%]
- suicide [4%]
- COAD [4%]
- other [25%]

PCG [a] aims to target mental health (measured by the parameter of reducing the numbers of suicides) and provide additional family support. It includes specific programs to address the health needs linked to high levels of drug abuse in the area, including needle exchange schemes. The area currently provides large numbers of formal substance misuse treatment programs.

Within the other two more affluent areas, particularly the PCG with high numbers of elderly and retired people, programs of chronic disease management will target cancers, ischaemic heart disease, stroke and accident's. Approaches to address a broad number of health needs throughout the Health Authority, include smoking cessation strategies and targets to increase the amount of exercise taken by the population.

Finally it is interesting to note that this area has a powerful public health tradition, and a strong culture of community development, involving a multi-disciplinary, inter-agency perspective to addressing the local public health agenda is relatively well developed.

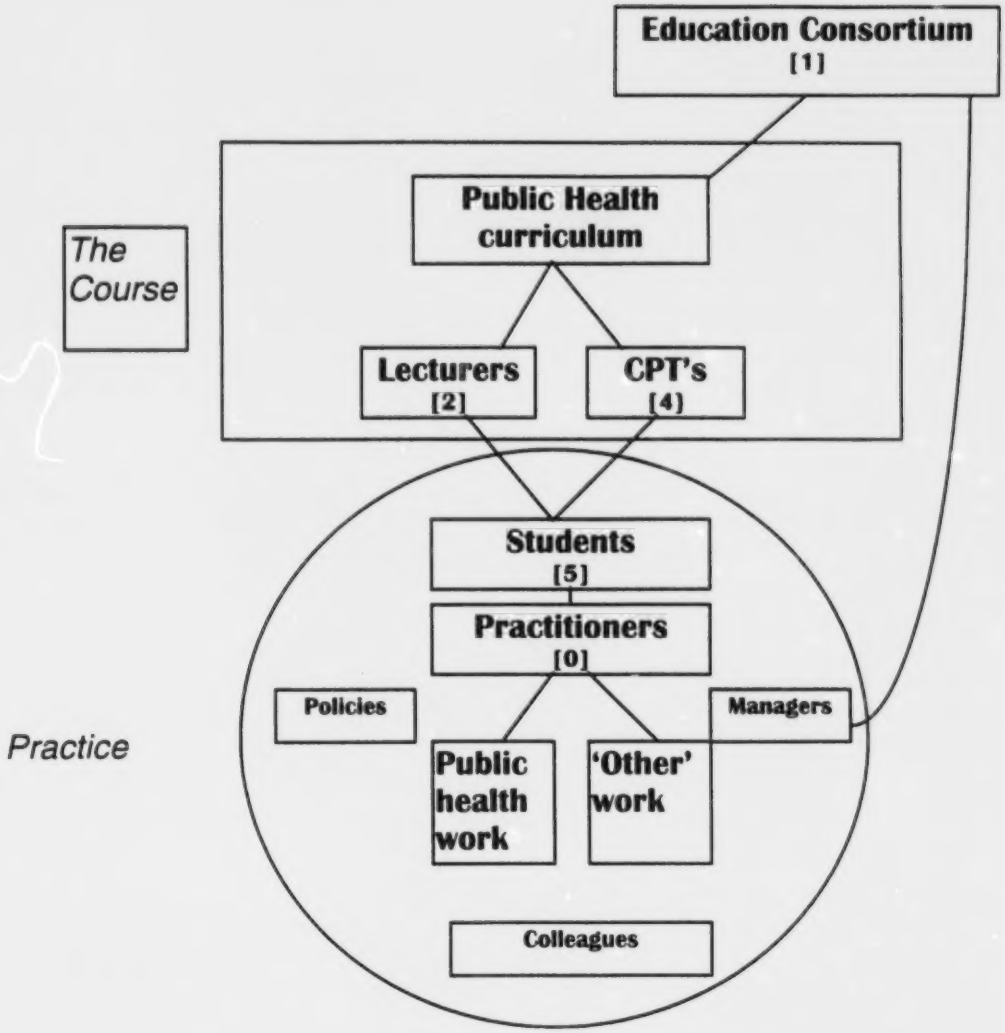

Figure 4 Site 12 - Data Sources (See Appendix 2 for numbers & roles of interviewees)

5.3.2. Conceptualising and Integrating Public Health Within District Nursing Practice

Learning Public Health: Lecturers' Perspectives

Public health was seen by one lecturer interviewed (RMLDN) as having a focus on the population rather than the individual, but also as something which was a participative process with communities " *I tend to see elements of things like community development being a big part of it.*" This was seen by this lecturer as moving away from traditional professional-led remit to a much broader perspective, although still including epidemiology and traditional medical science. This contrasted with her view of primary health care, which she defined firstly in terms of location and organisational structure - i.e. that it was based in GP practices. Health promotion was seen as a sub-set of public health, both contained common areas and interests, the difference identified by the lecturer being that public health was *"far more of a dialogue than a top down sort of approach."*

The importance of participation and dialogue was also reflected in the areas that this lecturer prioritised in the curriculum. These areas included group work and group skills, as well as exploration of issues of advocacy. This, pointed out the lecturer, might necessitate preparing practitioners with assertiveness skills in order to help them take on a public health role. The lecturer also felt that some knowledge of areas such as epidemiology was needed, but that it was important that the curriculum achieved a balance between the two areas of medical knowledge and relationship skills.

The complexities of working with communities were outlined by this lecturer who highlighted issues such as ownership of developments and ideas, and the range of solutions and strategies which may be offered by different groups, with no one approach, including the professional one, being necessarily the right one. The lecturer talked about *"perspective transformation, this idea of looking at it from the different perspectives"* as being crucial for the preparation of practitioners for the public health role.

In terms of practice, and the skills that district nurses needed to function, this lecturer gave examples of being able to read public health reports and apply them to practice, but again emphasised the importance of group work and relationship skills. These relationship skills were not only seen as necessary for working with clients, but also with other professionals and agencies. The key skill, however was in being able to cross boundaries between professionals and clients *"dealing with people who may see you as being from a totally different planet."*

The course was described by the lecturer as providing a forum for developing "*perspective transformation*" and an awareness of the "*landscape*" that nurses are working in. Also important was developing an awareness of the political and policy context of practice More generally, the lecturer argued that there had been a change from a model where theory was seen as driving practice to one where practice had become central, and practitioner knowledge was more valued. In this model, the lecturer described course sessions as constantly returning to practice, and exploring

how theory and practice can be integrated. As part of this process the lecturer described reflective skills as being crucial.

While all of these skills were important, when asked which were specific to district nursing, this lecturer emphasised reflective skills. This importance was not necessarily due to the specific activity involved in district nursing, but due to the context in which district nursing took place. Changing policies and philosophies of community care had, argued the lecturer, meant that the role of the district nurse had changed considerably, and would continue to do so. In these circumstances, the ability to reflect on practice enabled district nurses to respond to and shape these changes *"district nurses themselves are thinking a lot more about their role and where their role is going, and how their role fits in... [with] a more public health role."*

The ability to reflect was not always welcomed by students' colleagues. The lecturer gave an example of one student who had said that the course should *"carry a government health warning [because] she'd open her mouth about something and they said oh yes we know you're doing a degree... and it changed the relationship."* On the other hand, the course could also increase uncertainty about practice, in a way that the lecturer thought was challenging and positive, as nurses started to question their assumptions.

The barriers to doing public health work were seen by the lecturer as being primarily in the attitudes and ideas of the staff that newly qualified district nurses went out to work with *"who aren't too sure about the changing role and might want to keep it where it is,"* although she perceived managers were felt to be generally supportive.

The barriers to teaching public health were seen as lying in the potential lack of clinical credibility that lecturing staff might have. In addition, another problem that the lecturer identified was the way in which students came to courses *"looking for answers and wanting things nicely boxed off."* If the teaching role was more about promoting reflection and challenging assumptions, then this could cause some tensions.

This lecturer described practice links as very important in resolving these tensions, and in keeping up to date with new developments in policy and practice. Contact with Community Practice Teachers, however, was limited for this lecturer, although others in the teaching team did have more contact. The lecturer was unclear about CPT involvement in the process of assessment and also about placement experiences, in particular whether these would be arranged to ensure that students were able to see community development in action.

Nonetheless the lecturer felt that the reflective skills that students developed would form a firm basis for integrating theory and practice, and enabling students to engage in public health practice and community action initiatives, and also manage change in their practice. The lecturer did, however, voice some concerns about whether the course needed to address issues about the relationship between the District nurse and the GP practice more explicitly.

When discussing preparation for multi-disciplinary practice, the lecturer cited examples of social work students being involved in modules, and suggested that this was worth expansion and further development.

In terms of the future of public health roles in district nursing the lecturer expressed some concerns about the opportunity being lost if nursing did not act now, but also that if only some nurses took forward a public health role then this could cause a split between them and those nurses who remained in a more traditional role. Another threat would arise if issues of power were not tackled, particularly between doctors and nurses. This lecturer also argued for more emphasis on public health in pre-registration nursing.

The second nursing lecturer interviewed talked about public health in contrast to her past experience - in her early days of training it had been based on a very traditional model, with visits to sewage works and an emphasis on hygiene and sanitation. Because of this experience it was something that the lecturer had *"jumped away from."* This lecturer also described public health as being very covert in district nursing practice. Nurses engaged in public health practice by drawing people's attention to concepts of public health which the lecturer itemised as hygiene, disease, vaccinations, safety in the home and accidents. This was however, described as being implemented without a structured framework.

Primary health was described as *"the vehicle which would carry public health"* This was because primary health *"had the networks"* and was the *"first line."* Health promotion was seen as something which was part of primary health and public health, indeed the three ideas were described as being joined rather than separate.

When asked about examples of public health practice, this lecturer gave examples which reflected the traditional public health model of hygiene and sanitation, but pointed out that district nurses often get involved with patients when unhealthy lifestyles had already taken their toll, for example in the terminal stages of cancer. The public health role here, therefore, was described as providing advice to family and friends. However whilst this is undoubtedly a vital function within the district nurse role, the reader might question whether it actually constitutes public health work.

The lecturer talked at some length about working in primary care teams and the complexities of multidisciplinary practice, and also about the importance of health promotion in district nursing. When talking about the public health skills required by district nurses, the lecturer emphasised interpersonal skills, but mainly on an individual rather than community level, for example being able to listen and make people feel at ease. This lecturer did not identify any skills which should be specific to district nurses, saying that they were generic skills.

The lecturer commented on the practice experiences of students, saying that many of them were very frustrated by the lack of opportunity to develop a role within a hierarchical system. The barriers to developing a public health role were however, described by the lecturer as arising from the nurses attitudes, and especially their emphasis on *"hands on care."* As the lecturer put it, district nurses think that if the only talk about things they "come out thinking I have done nothing." The solution to this attitude problem, however, was suggested by the lecturer as being about *"bringing* [them] *more into public health"* through legislation and policy.

Barriers to teaching public health were seen as a limited amount of knowledge on the part of teachers, and the lecturer stated that she needed to update knowledge more. Things that would help teaching public health were more *"health symposium type work"* and a move away from the medical model. This lecturer described the public

health element of the curriculum as a theme which ran through the modules on the course. It was not presented as a discrete unit.

The director of public health who was interviewed also acted as a lecturer on this course. Interestingly this person saw public health as being very much about involving and empowering communities through development programmes, not about a biomedical approach. The lecturer cited examples of projects that they had been involved with in the developing world, where issues about nutrition for example, had been tackled by developing different farming techniques in the community. Again primary health care was seen as defined by staff/service structures, and health promotion was seen as a sub-set of public health. This person had been on a public health training programme which was useful because *"it gave words to the thoughts."*

This individual was not particularly practice-orientated - taught mainly statistics and epidemiology, so was unclear about the barriers to implementing public health. However, one thing that they felt could facilitate public health practice in district nursing was *"a good doctor!"*, perhaps implying that medical colleagues also needed to include public health approaches in their work if nurses were to do so successfully.

One value of teaching public health on the course was its ability to change nurses attitudes *" they come into the course with the feeling that they will never be able to do this.. and for me the biggest challenge is to get them to believe that they could do this."*

The views expressed were very different, however there were some similarities between lecturer 1 and the medical lecturer in that they both saw public health nursing as being about community development, and health promotion as being a part of this. Primary health care was defined by both by organisational characteristics. Lecturer 2 seemed to have a more traditional view of public health, and seemed to view the district nurses contribution in terms of traditional tasks and practices. The barriers to teaching and learning were most explicitly identified by lecturer 1 who was clear about the need for educationalists to have closer clinical links and more clinical credibility, as well as the imbalances in power in community care.

Overall, therefore there was a mix of views, from the more radical, *"public health as public empowerment"* view, to *"public health as hygiene."*

Learning Public Health in Practice: Community Practice Teachers

Four Community Practice Teachers (CPTs) took part in a focus group at this site. When asked about what public health nursing meant to them as district nurses, a member of the group cited a project in a deprived area where joint forums were organised with communities to identify issues and concerns. One concern had been smoking, so a group had been set up to support people. In addition the group started to talk about more organisational activities, such as membership of PCG boards. The group members also talked about available information on health problems in different areas, and how it could indicate problems. From that however, solutions had to be worked out with the people in the areas.

When asked about primary health care, the group talked about the importance of multi-disciplinary working and the role of education in breaking down barriers. One member pointed out that this working was not an automatic result of sharing buildings, as barriers could still remain. Some of these barriers were attributed to non-professionals or managers, rather than staff involved in care delivery.

Health promotion was seen as an informal process that could inform practice in a number of ways, from the individual health assessment, to running a range of client groups around specific health issues, for example groups on women's health.

One advantage that some group members identified was working with people who had dual qualifications. For example one district nurse had a health visitor qualification, and worked with a health visitor who had been a practice nurse, and this had helped them to understand each other's roles and pool skills.

The group members identified some barriers to developing a public health role in district nursing, and these were partly to do with the persistence of traditional views of practice. The nurses observed that students often felt stifled if they were working with someone who was not moving on, or working in more progressive ways.

The skills that the group identified were mainly about communication skills and group working - similar skills to those identified by one of the lecturers at this site. They also identified presentation skills as being important, as the practitioners *"had to come across as being very confident."* Some of these skills, however, were thought to be gained with experience, and had to be developed in practice, and so the course could not be expected to give practitioners them. The group pointed out that too much could be expected of specialist courses, and that people could come out of them with more questions than answers. There was also an element of personal development identified by the group, in that they suggested that individual district nurses could identify specialist skills that they needed in their job, and pursue these through a range of ways. There was, however an issue about how training needs could be identified, and furthermore, whether courses and funding would be available.

Suggestions for skill development after qualification included strategies such as shadowing and working with different professionals in different circumstances to develop skills. For students on the course, however, identifying learning needs was an important part of the CPT role, in that students would not always be aware of the gaps in their experience. CPT's could help in this process and organise experience so that these gaps could be filled.

Constraints in practice which limited the abilities of nurses to carry out a public health role were identified. These included work loads which meant that contact with clients had to be *"short and sharp."* Heavy workloads meant that public health work also had a low priority.

A facilitating factor mentioned was involvement in public health projects. The example mentioned had had substantial funding which gave it status and priority in the eyes of practitioners. Projects like this gave practitioners clear examples of public health practice and increased their understanding.

Learning and Doing Public Health Work: District Nurses in Practice

At this site, five newly qualified practitioners were interviewed. The response to the question about what the group thought of when they thought about public health nursing elicited a number of topics; infectious diseases, health promotion, education, and epidemiology. Further prompting elicited subjects like the city health plan, and some mention of *"the White Paper,"* but there was little response beyond a list of topics.

Primary health care elicited more discursive responses, and these were mainly about service structures, such as voluntary agencies and social services. The responses did, however include the identification of communication and collaboration as key ideas. There was also some discussion about principles behind primary care, which one member asserted were about choice. These were felt, however to be constrained by resources.

The response to the question about health promotion elicited the comment that *"the definition is empowerment isn't it, not labelling people?"* Further comments suggested that health promotion was about raising awareness, but that it had to take place against a background of social circumstances which determined behaviour and choices. Other comments which picked up on these constraints began to identify environmental issues and housing issues, as well as issues about the extent to which people felt empowered.

There was some unfamiliarity with terminology - for example one person asked *"what is it when they target community and get the health promotion in?"* to which a colleague answered *"health needs assessment."* This, however was picked up by another group member and led into a discussion of risk assessment of people over 75.

When asked to give example of public health issues, the practitioner group offered the example of a falls project, where when older people had fallen, a nurse went out to them and assessed their environment and mobility. Another member cited a pressure sore audit that she had been involved in which had led to a group forming to put on educational events for the public.

In their comments on district nursing, the group offered several definitions, most of which centred around delivered hands on care in the patients' own home. This implied a model based around individual care rather than a public health concept, and there was some evidence that it was the direct care that the group valued. One member quoted with approval a GP who had said *"The difference between a district nurse and a health visitor is if you wanted some practice knowledge you asked the district nurse. If you wanted something a bit more high faluting' then you asked the health visitor."*

Summary of District Nurses Critical Incident Logs

Students and Community Practice Teachers had, as requested, kept Logs of Public Health Critical Incidents - see Appendix 4 for examples. These practical, written examples demonstrate that district nurses conceptualised public health from an individual or group perspective. They were framed within models of primary, secondary and tertiary prevention. However, there were differences between the newly qualified and the more experienced practice teachers' stories. Whilst an illness perspective underpinned the newly qualified district nurses' examples of public health, a broader approach to health promotion was evidenced within the CPTs' examples. This included evidence that they appreciated the implications and inter-connected issues impacting upon collaboration, resources and the political agenda's influence on the public's health.

The perceived district nursing contribution to public health was grounded within a health promotion model. This was translated within the University's curriculum documentation where health promotion featured strongly.

Professional Leaders

These leaders included a practice development nurse, and a professional development facilitator employed by a local Trust and a professional nurse lead on secondment to the Chief Executive. Whilst there was evidence of common ideas and beliefs around the notion of public health, there were also some differences.

When asked about their definition of public health, the professional leaders responded with a range of ideas and models. The common core, however, was the idea that it was about identifying needs at a community, rather than an individual level. While one respondent gave a definition which was that it was not *"caseloads and individual patients...*[but] *large groups of populations."*, other respondents gave examples which seemed to reflect an individual approach, such as encouraging healthy life-styles in teenagers. One respondent argued that public health could take place at a number of different levels, ranging from the neighbourhood to the caseload level.

The professional leaders all defined primary health care in terms of it's organisational base, i.e. the GP practice. One respondent argued that the term primary care was a misnomer, because when people went to see their GP they already had a health problem, and that preventative work was often neglected. Primary care as a concept seemed to elicit a more detailed response from respondents who talked about the day-to-day issues of delivering care at some length.

Health promotion again was a concept discussed in detail, with respondents giving a number of examples of projects and schemes that they knew about or were involved with. This level of district nurse activity was not apparent in public health work, however, and one respondent commented that *" I'd probably struggle to think of roles of district nurses in public health."* This, however, was felt by this respondent to be an area of potential change in the future, particularly as district nurses contributed to the health improvement plan.

The skills and knowledge that respondents identified as being necessary to fulfil a public health role were very wide-ranging. Respondents identified a knowledge of epidemiology and a knowledge of local resources as vital in developing community plans, while another identified a knowledge of service structures as essential if anyone wanted to get things done. Following from this, the ability to work across boundaries was identified as essential.

The respondents had some difficulty, however, in identifying which of these skills were generic to all public health nursing, and which ones were specific to district nursing - one respondent mentioned Macmillan nursing, but it was unclear how this was being related to public health nursing. In addition some tensions were identified between the generic skills of accessing and analysing information and the traditional views of district nursing as being mainly a hands-on delivery of care activity. As one respondent put it *"they still perceive their role as very much hands on, giving treatments and seeing to patients."* Correspondingly, the skills of being able to access information and analyse it could be dismissed by colleagues *"there's a school of thought that says that the nurses that come out of these courses are very good at shuffling round libraries and standing in bus queues but not much good at patient*

care." In other words if skills are not perceived as 'doing' or 'hands on', they may not be valued by district nurses.

The professional leaders had experienced a range of problems in developing their own public health role particularly when trying to work across agencies and sectors *"certainly in terms of non-health care, social care or whatever, I've found it very difficult to make any inroads at all, but there's nothing unusual in that."* For students and newly qualified staff they identified a number of barriers to developing a public health role, mainly about workloads and existing responsibilities. *"Workloads and case loads and referrals , people having to priorities in terms of their time, what they can delegate and what they can't delegate, so I guess that's the main barrier."* Another respondent, however, identified attitudes and expectations as a barrier, the emphasis placed on hands on care.

The picture painted by the professional leaders was one in which public health working by district nurses was still very much in it's infancy. Different agencies and sectors were not working together on public health issues, except for some specifically focused projects. In this environment, an understanding of the complexities of the system was vital, as well as the skills to work across and with groups. Overall, however, there seemed to be little easily-identified public health work happening for students and new practitioners to use as examples for their own practice.

Commissioner

The commissioner's view of public health was that it was something wider than curing disease, took into account environmental issues, and had a focus on child health. Primary health care was again identified in organisational terms as being GP practice based. Health promotion , interestingly, was defined broadly in similar terms to public health, *"Keeping well, helping people get better... what you are looking for is a critical mass of the population to change in a small way to effect a large change in the health of the community."* The commissioner, however, gave a very broad description of health promotion activity, including such things as setting up credit schemes to alleviate financial problems, and this contrasted with descriptions of public health which gave, for example immunisations and meningitis scares as examples - this seemed to be a medical model of public health rather than a social one.

The skills and knowledge that the commissioner identified as being necessary were similar to other respondents in that they included knowledge of epidemiology and research. The commissioner, however, asserted that additional skills needed were *"not all that great because the nurses themselves , the kind of training they have had make them very competent."* It was further argued that the kind of people coming into district nursing would know that there would be differences in networks and would be confident in working across agencies. However the commissioner also felt that group work skills should be part of the curriculum.

The commissioner saw her role as that of promoting the involvement of district nurses in public health activity and potentially ranged across a several sorts of initiative. One example might be that of ensuring nurses were involved in looking at contracts intended for educational consortia, another might be ensuring that they were included in campaigns and projects.

When asked about the day-today practice of district nurses, and their public health role, the commissioner identified the significant contribution that they made as being in *"the second or third stage of health promotion, public health, helping people get better, helping people cope."* This description suggests an individualistic, illness-focused perspective to their work rather than a broader public health role which addresses community needs. When talking about the barriers to developing a public health role, the commissioner seemed to be talking about public health per se, and pointed to a general ignorance of changes in public health, that it was no longer just the consultant in public health who had a role.

The commissioner felt that one of the advantages district nurses had in thei: public health role was the good-will from the public, who saw them in a positive light. The commissioner recognised, however, that they needed to be given experiences to prepare them for taking a public health role. The commissioner also felt that some curricula did not prepare students to understand the policy dimensions of practice, which was a limiting factor.

When asked about future hopes for public health, the commissioner hoped that there would be a much more collective approach to health care *"every individual appreciates that they have a greater part in the whole."* Against this, however, were a range of media images which focused on acute care settings as being the heart of health care. Dramatic life saving activities which excited the public imagination could prevent the importance of public health being recognised and services funded adequately.

5.4. Case Study Site 15 - Practice Nurses

In common with each of the sites, this case-study examines the effectiveness of the key learning outcomes for the specialist community practitioner programmes, as demonstrated in practice, and explores the developmental implications for specialist practitioners in the context of public health. This particular case-study focuses specifically on general practice nurses.

These data were collected from a similar spread of practitioners and stakeholders, as described in the multi-disciplinary case-study site.

5.4.1. The Context

This case-study was undertaken with a University that serves a large, urban area. Whilst the city's economy has grown in recent years, it has not kept up with the national trend. Massive restructuring of the local industry in the area during the 1980's, resulted in higher than average unemployment. It remains today at 2% above the national average.

There are large variations in health and economic resources between the populations of the wards. Wide variations in ill-health within the city is of explicit concern for the Health Authority, as measured by the Standardised Mortality Ratio (SMR). During the early 1990's the SMR was 10% higher than the national average. Latest estimates confirm that in several of the inner-city wards, the SMR continues to exceed the national rate by 25%. However there have been recent improvements in infant mortality rates. Low birth rates are high in the inner city wards, particularly those with the highest proportions of ethnic minorities. The ethnic minority population is estimated to be 6.8% of the total population. This is in line with the national average, but relatively low for a city of this size and position.

As a whole, the city ranks within the worst 30 of 354 local authorities in England, as measured by a deprivation index. Average earnings in the Region have been falling, relative to the national average. The decline in male earnings has been dramatic, in the wake of job losses and restructuring in the steel and coal industries. Equally, female earnings have undergone a gradual decline. Twenty percent of all households in the city are receiving Income Support. Households receiving Income Support includes one in five of all children under eighteen years.

In summary then, the profile of this city within which these community nurses practice is characterised by poverty and inequalities in measurable health outcomes.

5.4.2. Public Health Background in the Case-Study Site Area and Implications for Nurse Education and Training

In early 1998, public health stakeholders employed within this case-study area, undertook a local evaluation of the non-medical contribution to public health work. The paper this produced outlined a local 'stock-take', describing the current level of skills and examples of public health practice, and recommendations for the Primary Care Sub-group of the local Consortium to consider. The objective was to describe the policy and professional issues for public health as a means of identifying the education and training needs of non-medical practitioners (including nurses) that required addressing by the Consortium. The stock-take identified variety of current

public health practice was identified in the area, however only one example reflected the work of practice nurses, and this was as part of the PHCT. It was this:

- A PHCT undertook a health needs assessment of the practice population, prioritised health needs and developed a program of accident prevention for older people and set up a young peoples health clinic.

The stock-take identified, for the training Consortium, a number of issues that needed to be addressed if nurses were to contribute to the public health agenda:

- There was a lack of understanding of public health and the professionals contribution, at all levels and in many settings.
- Few nurses have developed specialist skills in public health.
- The public health work of practitioners in primary care is underdeveloped and under-used.
- The provision of training and education in public health does not currently meet service needs.
- A lack of inter-agency working by health care professionals on public health issues.
- Finally, whilst there was an acknowledgment that not all these issues can be addressed by the Consortium, the specific areas of education and training are domains where change does need to take place.

Whilst it was identified that individual disciplines had differing needs in terms of educational preparation for public health practice. In order that the Consortium implement change, the core skills and competencies needed to prepare the workforce for effective public health practice were identified:

- An understanding of a population approach.
- Current health and social policy.
- Inequalities in health.
- Interpreting health information.
- Interagency working and knowledge of the functions of the Local Authority.
- Health and disease.
- Effective health promotion methods.

Evidence that the knowledge to address these core competencies were taught by educationalists within the local specialist practitioner course and also that they were absorbed by nurses in practice, was sought within the data collected from this site. This local evaluation was completed in early 1998, and the case-study site was visited by the research team in late 1998. Concordant themes emerged from both data sources.

Recommendations for an educational framework to facilitate change was submitted to the Consortium for discussion and implementation:

- Training and education in public health should be integrated into the core curriculum of both pre and post registration education programs.

This recommendation contains the implicit assumption that public health education was not currently present within these programs. Indeed this emerged from the route module leaders interview, who believed that public health skills, which she perceived

to have been taught in past curriculums were no longer taught! This evidence, therefore supports the principle that the skills for delivering public health practice are not perceived to be included within the course curriculum and thus may not be taught within the program.

- Furthermore, education programs need to be established as a priority for primary care practitioners to enable them to tackle root causes of inequalities in health, thus enabling them to contribute to the public health agenda of PCG's and Health Improvement Programs.

This recommendation has particular pertinence for the continuing development of practice nurses, who work as the employees of GP's. The evidence suggests that this imposes constraints on their development that is peculiar to the practice nurse role. In addition, many practice nurses will become involved as nurse representatives on the PCG boards and need to develop skills and which enable them to understand and work on population approaches to promoting the wider public health. If the traditional course has not prepared experienced practitioners with these skills, the student's role models who support and assess them for competent practice will be unable to do so effectively. (There is evidence throughout each of the case-studies that support the view that CPT's and assessors are powerful influences on both the beliefs and skills of newly qualified specialist practitioners). Attention may therefore, need to be focused on the development of public health knowledge and skills, of practice nurse assessors.

- providers of education will need new skills and knowledge to enable them to teach public health to non-medical professionals.

The RML of this course believed that public health was integral to the practice nurse role, however, she also commented that many nurses did not understand the role. The evidence generated from practitioner interviews, supports this view. The critical point here then, is the responsibility that nurse educators have for the *explicit* emphasis on public health practice within the specialist practitioner course.

- Learning needs to be flexible and take place in several different ways, such as shadowing, learning sets and practice-based workshops.
- Multi-disciplinary training to include doctors.

5.4.3. Access Issues

It was a relatively straightforward matter to contact and engage stakeholders such as professional nurse leads in a local Trust, the educationalists specifically responsible for the practice nurse route, Health Authority commissioners of practice nurse education and Directors of Public Health. However, this was not the case with practitioners, including newly qualified specialist practitioners and their assessors. It was decided to contact the Chair of the LMC, as the representative of GP's who were the employers of these nurses. He was sent a copy of the study protocol and declined to be interviewed.

Accessing the practice nurses to interview as a group, proved particularly problematic for many of the reasons experienced in the multi-disciplinary case-site. In a nutshell, practice nurses as a discipline often work in isolation from other practice nurse

colleagues. Crucially, they are the employees of GP's, and the practices may be spread across many miles within the University's catchment area.

Efforts to contact and engage practitioners and their assessors (practice nurses colleagues) proved problematic. Letters and consent forms were sent to those whose addresses had been provided by the University (n=22). This produced a poor response (7 replied with only 3 agreeing to be interviewed). This response may have been a result of a number of pragmatic factors. Comments on the consent forms illustrate some of these issues:

[1] "I am willing to participate in the study. Unfortunately I live 40 miles from the University and do not finish work before 6pm."

It was not necessarily a lack of interest in the study that prevented practitioners attending:

[2] "Sorry, unable to attend as I am working, but am very interested in your work."

Attempting to contact one practice nurse prompted a reply from a GP employer, who declared it *was "most unsatisfactory"* that we had approached the nurse directly, stating *"you have my permission to approach her on that day only* [the nurses day off]."

To summarise then, these data are consequently limited and represent the views of a very small number of newly qualified practitioners who were interviewed individually (n=1), in a pair (n=2) and on the telephone (n=1). Total n= 4. The assessors were interviewed in a pair (n=2) and on the telephone (n=1). Total n=3.

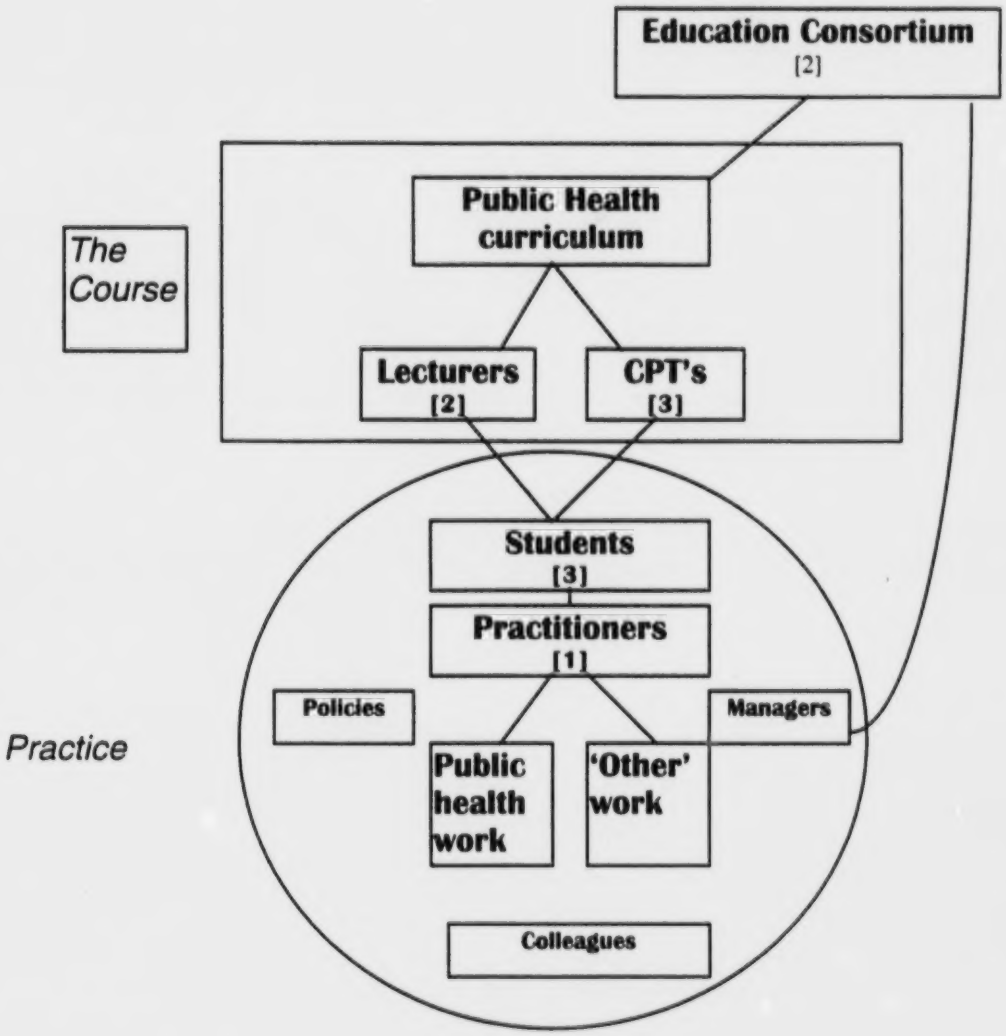

Figure 5 Site 15 - Data Sources (See Appendix 2 for numbers & roles of interviewees)

5.4.4. Conceptualising and Integrating Public Health within General Practice Nursing

Learning Public Health: The Lecturer's Perspective

At this site it was only possible to interview the Route Module Leader for the Practice Nursing Route. This lecturer believed that public health was fundamental to the nursing role. Whilst her own training, some years previously, had focused rather narrowly on public health as 'hygiene', *"we went to see how sewage was treated, it was considered part and parcel of our training,"* the loss of this sort of experience was nevertheless regrettable.

This lecturer saw public health and practice nursing as going *"very much hand in hand"*. Despite this belief the lecturer commented *"I also think that nurses are not as aware that they have public health remit as they should have and that they could have."* She believed however, that this was changing and the lecturer argued that this was *"driven by nurses out in the community because they're being asked to do more and more in the public health role."* These comments suggest a view that changing roles and demands are subsequently increasing awareness of public health issues among practice nurses. Despite professional and political expectations of an 'enhanced role' in public health for these practice nurses, the reality of constraints imposed by their roles as employees of GP's, limited their actual practice to addressing health needs on an individual level.

Interestingly, (and in common with the new public health White Paper, [DoH 1999] the lecturer envisaged the continuing development of public health to include a range of other groups, including occupational health nurses, nurses working in the private sector and a range of other roles. While the nurses in these roles might not have identified their role and contribution to public health, the lecturer believed that this would develop.

The lecturer viewed health promotion as integral to practice nursing *"it's everything you do, certainly as a practice nurse."* This was becoming more evident as practice nurses started widening their activities, for example going out to schools *"they are taking the message out."* This lecturer gave examples of students going out and doing health promotion work in a variety of different ways.

The lecturer also described the concepts of public health, health promotion and primary health care as being extremely difficult to separate, and gave examples of practice nurse activity where these would be integrated. One example given was travel advice, where people would come for immunisation, but where the nurse would also give opportunistic health advice, and health assessments. Another example was offered where nurses were involved with chronic disease management on an individual level, such as asthma, however the practice nurses contribution to public health went beyond individual treatment, into raising awareness of environmental issues.

When discussing influences on her ideas about public health, the lecturer cited a number of work experiences and roles, for example working as a *"troubleshooter,"* establishing practice nursing across GP practices. In this role she had had the *"power of the health authority behind me,"* indicating that this reinforced the authority and legitimacy of public health work in this instance.

The skills that the lecturer identified as important, were primarily about networking with other agencies and workers, and developing the ability to access information. Practice nurses also needed the ability to reflect on practice in an ever-changing world. They need knowledge about legislation and the political context, current issues, IT, change theory. The similarities between skills needed for public health practice had led this team to feel that they could not separate specialist skills from core skills, and had designed the course accordingly.

The barriers to practice nurses developing a public health role were seen as GPs and Health Authorities, but problems also derived from a lack of confidence within these nurses themselves, particularly those who had not completed the specialist practitioner course. Nurses who *"hadn't made the connections with public health"* were similarly limited in their approach and ability to practice. The lecturer argued that many individual nurses were keen to develop their skills, to the extent that many funded themselves for this course. The lecturer also gave details of additional workshops and study days in which public health issues had been addressed through, for example, child health issues, and which had been well-received. The workshop had involved public health consultants, and exercises such as role-playing.

Competency assessment for practice nurses had caused some problems when the course had first been established, given the dearth of qualified practice nurses available to supervise the 'students'. However more recently graduates from the course had been used to assess subsequent students.

Learning Public Health in Practice: Practice Nurse Assessors

As described above, only three Practice Nurse Assessors were interviewed. When asked about their images of public health, one responded with hygiene themes, such as sewers and infection control, while the other described the *"new image"* as being much wider, and included mental health, health inequalities, and political dimensions of health. They also commented that while at one time public health had been associated with the public health doctor, that the staff involved in public health had now become much more diverse.

The discussion about primary health care was primarily about financing and resources, and the problems about limited resources. Similarly the discussion about health promotion was mainly about the practicalities of trying to do this with limited time, and the necessity of doing *"bread and butter things."*

One of the major barriers that these assessors perceived surrounding their role focused on the system. They did not actually work with their students, who may be more experienced in terms of years qualified. They were always based at different sites (GP practices). The assessors role differed considerably to that of their health visiting and district nursing CPT colleagues. In the first instance it was taken on voluntarily, and involved no extra remuneration and the time commitment was their own *"we are not paid for it as practice nurses and we are in a position of choice, it's not as if being an assessor is our job, we are approached by the student and can say no."* Indeed these practitioners were clear that they would only perform this voluntary function for those practice nurses they had confidence in. This contains major implications for the provision of support and training for this particular discipline. The expectation that these practitioners would be teaching knowledge for public health is an unrealistic one, the role was perceived as entirely a supportive one *"...we are not teaching them*

are we? [asking colleague] *I don't believe an assessor is a trainer... I see my role as very much a supporter.*" They did believe the support they provided constituted a two way process *"I am looking for K to improve me as well."*

Learning and Doing Public Health Work: Practice Nurses in Practice

Only four practice nurses could be interviewed at this site (see discussion above). The definition given by them of public health was about *"looking at issues around everybody's potential health,"* and the example given was *"a leakage from a steel works or factory or something like that."* The definition of primary health care was organisational - *"first port of call, GP."* The definition of health promotion was very basic - *"encouraging individuals to take responsibility for themselves by giving them the appropriate information."*

When asked to give examples of public health work that they had been involved in, the example given was responding to a local meningitis outbreak. The educational needs that they believed pressed they needed to full-fill their public health roles included input on understanding policies and strategies for promoting awareness, and they did not feel that these had been addressed on the course. However the practice nurses were unable to specify what they would have liked included on the course.

When asked about areas that they felt most confident about, one nurse replied that this was *"management of my condition,"* meaning the health problem that she specialised in. The knowledge she had gained had been developed from project work on the course, rather than that it had been covered by the course curriculum. Of course project work aims to provide students with opportunities to study specific areas of interest in more depth and breadth.

Barriers to their implementing public health nursing were identified as time, but also the geographical spread of the patient group in a practice. As patients came from a range of different environments across the city, it was difficult to identify patterns, but also to devote time to one health problem, to the neglect of other patients from different areas.

The stimulus for public health work was described *as "people coming in and talking to you, actually promoting the issues themselves."* This individual perspective was also reflected in their response to questions about working collectively. One nurse responded by saying *"It's more a case of your own empowerment, you know, your own ability to do something, rather than collectively."* In other words the notion of a collective approach to improving local health was considered to be beyond the remit of practice nurses.

Overall, the practice nurses did not feel that they had been adequately prepared for a public health role, but perhaps more importantly, they did not have the opportunity to develop public health skills in practice on completion of the course. Whilst the course increased their awareness of different disciplines and roles, they had little opportunity to work with other disciplines in their practice. Cross-organisational working was largely a concept beyond their repertoire, dues essentially to the structural constraints imposed on practice nurses.

Summary of Practice Nurses Critical Incident Logs

Logs of Public Health Critical Incidents were completed by both newly qualified practitioners and assessors - see Appendix 4 for examples from these. The stories of

public health work described by practitioners were largely characterised by them as seeking ways to both expand their professional role, and to develop what they believe is a better service for their surgery's clients. In other words, a service based on a health promotion and life-style change model, rather than the sickness or medical model. The stories also represent small examples of attempts to move from working with individuals to work with groups and the wider community (for example, youth club attendees). Nevertheless, it was unsurprising that many of these examples focused on expanding the service within the general practice itself- the raison d'être of practice nursing. These projects seemed to be driven by the practice nurses and were only sustainable by the sheer determination of these individuals. It must be appreciated however that these examples derive from a very small self-selecting sample of practice nurses who may have a particular interest in public health approaches to practice. In other words these examples may not be representative of practice nurses in general.

Further evidence of structural/role constraints emerged from these data. The practice nurses perceived the underlying structure of their jobs as different to the community nurses who were employed by Trusts (such as health visitors and district nurses). As already discussed the practice nurses were employed directly by GP's and thus special expectations, demands and sometimes constraints were placed upon them. This could prevent them working from a public health perspective as there was a perception that their GP employers were more interested in the nurses application to individual tasks and the throughput of patients. There was evidence in these data that practice nurses believed health promotion and public health were peripheral considerations for their employers.

Public Health Work in Context:

Trust Manager

This Trust manager had a district nursing background, and had had limited contact with practice nurses, although she did comment on the tensions that existed between district nurses and practice nurses, as the practice nurse role had developed historically because *" the district nursing service wasn't meeting the needs of GP's."*

The manager did not think that practice nurses were developing a public health role, because of time constraints, and the need to deliver hands-on care. The manager, however, struggled to define public health when asked, simply commenting that she didn't think that *"we're achieving it too much at the minute."*

When asked about primary health care, again the manager did not define it, but simply commented on the progress made towards developing it. The goal of development, for this manager, was *"the integrated team approach."* There were some barriers to this - for example she cited the shortage of Therapists and the lack of funding, and the limited movement of resources from secondary to primary care.

When asked about health promotion, specifically with practice nurses in mind, again the manager did not describe her ideas but simply commented that she did not think that practice nurses had developed this role - *"it depends on how committed the GPs are and how much time they allow the practice nurses to give to health promotion."* Illustrating once again the control GP's exert upon practice nurses work and roles. The manager perceived health promotion as a specialist area, which needed specialist input.

When talking about the source of influences on these ideas, the manager cited some professional experience [as a district nurse], but also Government reports. These reports, while containing good ideas were, in the managers view, difficult to put into practice. When asked about the possibilities of practice nurses acting in a public health role, the managers responded with generalities, such as agencies working together. This discussion initially was very much at an organisational level, and did not refer to practice nurses specifically. When practice nurses were mentioned, the comment was that she did not think they could take a wider public health role " *I think it's as much as they can do is have a hands on role within the practice doing the immunisations, doing the blood pressures....* "

Specific health promotion activity was seen as more achievable for practice nurses [in contrast to broader public health work], it was part of their role within GP practices, such as special clinics. As with public health work, the manager did not believe they were in a position to see the "*wider picture*" of health promotion.

The manager had been involved in training and education, and felt able to comment on the skills that practice nurses would need for a public health role. These were, however, described as "*the skills that are required by the rest of us,*" profiling local populations and carrying out health needs assessments. The public health role also required access to information about populations, which the manager did not think that practice nurses received. Access to training programmes was also limited, while the trust had an in-service training programme, practice nurses could only access this if they were supported by the GP's that they worked with.

The manager did not have responsibility for training practice nurses and consequently, did not know much about the provision available to them. The manager clarified that practice nurses were outside the Trust, and therefore outside her remit. The lack of responsibility was coupled with a lack of value placed on practice nurses, beyond of course their ability to deliver routine, hands-on care at the command of the GP.

Public Health Nursing Lead [Health Authority]

Public health was represented by this individual from a population perspective "*population health is the total of individual health and it takes more than individuals to do anything about it. Its about addressing those dimensions that are beyond individual control, the organised efforts of society.*" Public health was all about a way of seeing and standing back to view the broader picture, "*seeing things with the public health eye, where you look for patterns.*"

Public health in Primary Care included a number of strands, including health needs assessment, multi-agency working and community development. These strands needed developing and strengthening within PCG's, which in combination with the health improvement programs were shaping them into public health organisations. It was perceived that whilst this would not necessarily alter the dominant discourse of individualism in general practice, it could *'legitimise'* public health as a notion for non-medical practitioners. Latterly public health has been perceived as *'fringe work'* for nurses. However, interestingly, and in common with the educationalist in the multi-disciplinary case-study site who perceived public health from a collectivist model, she believed that 'nursing', with its focus on caring for individuals actually impeded a population approach to public health practice.

The appropriateness of the collective role was perceived as questionable for practice nurses *"I see practice nurses... because obviously its an important job, to be done for individuals by nurses in primary care, that's what they should be doing."* In other words it was doubtful whether preparing practice nurses for the public health role would ensure a fitness for their purpose and practice.

In contrast to the other interviews, the broader perspective afforded to this individual, enabled her to describe a real, albeit limited, example of a practice nurse working within a public health framework. One practice nurse working in the most deprived area of the city, was collaborating with a community worker to address young peoples health issues. However this individual was perceived by the public health nurse lead, to be unrepresentative of practice nurses as a whole.

In order to prepare nurses for public health practice, the raising of their awareness surrounding the notion, was considered to be of primary importance, *"seeing with a public health eye... all preparation* [for practice] *should be an awareness raising journey."* She considered it unwise to be prescriptive about specific skills and knowledge, as she believed these would be dictated by personal and local needs.

She was quite clear that practice nurses were currently not trained to full-fill a public health role, however their particular strengths could potentially lie in filling the gap for public health practice for their GP employers. Indeed practice nurses could specifically contribute to public health work through their access to the practice population data base. She raised an additional barrier, which was the language of public health itself, *"I think if we talk about health improvement and their* [practice nurses] *role in health improvement, we may engage them better than when we are talking about public health."* In other words this could be remedied by approaching public health work from a health improvement perspective.

5.5. Case Study Site 28 - Health Visiting

5.5.1. Context

Site 28 serves an area with a total population of around 1 million. There are one major Health Authority and eleven Trusts in the area covered by the University. As well as major cities, the area includes smaller towns and villages. Jarman scores offer a proxy for likely GP workload. They are based on eight census variables (pensioners living alone, under 5s, unskilled workers, unemployment, single parent families, overcrowding, recent movers and ethnicity). Scores above zero indicate higher levels of deprivation. Whilst the median Jarman score for the Health Authority in Site 28 is -8, wards within the area have Jarman scores up to 58, indicating a high level of variation in health experience in the area. Mental disorders and musculo-skeletal problems are major contributors to the overall disease burden of the area. Cancers, heart disease and mental illnesses are the chief causes of premature mortality and disability. The University has run a BSc (Hons) Community Health Care Nursing since 1996. Full-time and part-time modes are offered. The course offers Health Visiting, Practice Nursing and District Nursing options, as well as a number of others.

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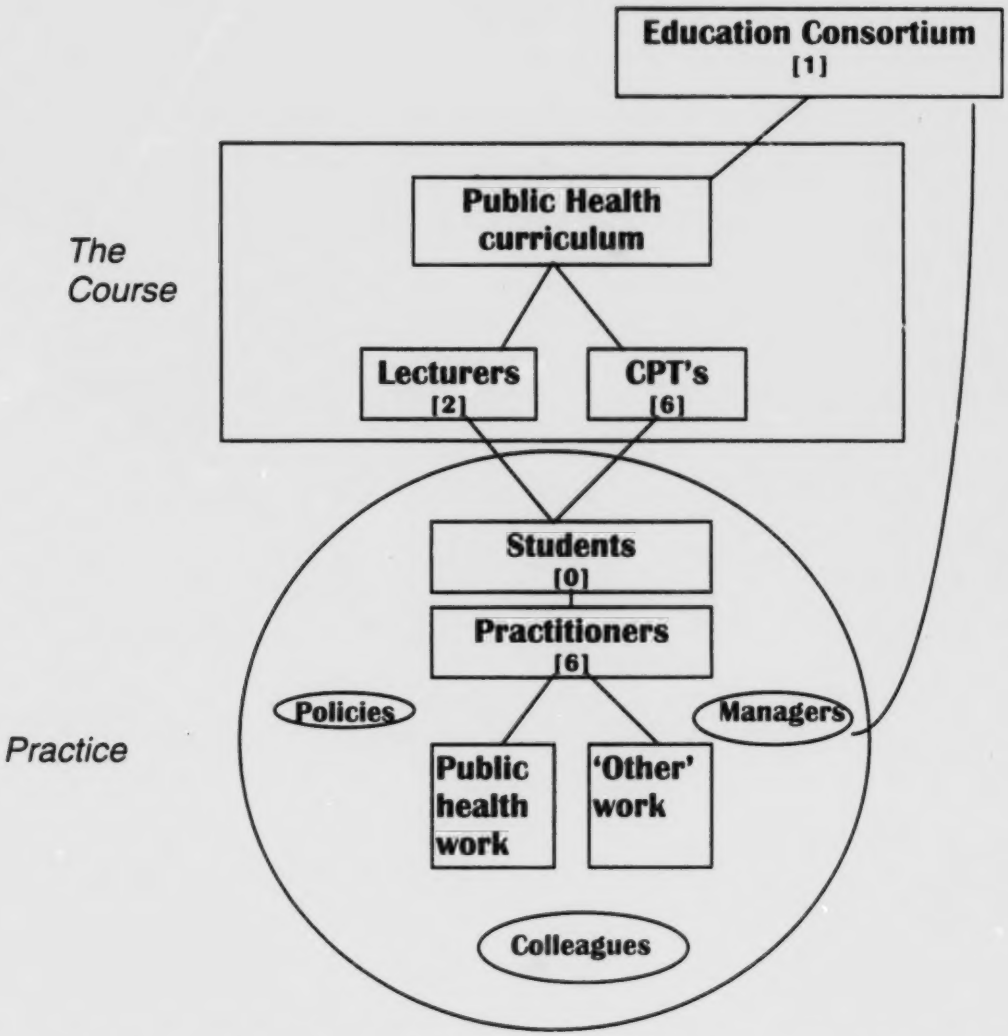

Figure 6 Site 28 - Data Sources (See Appendix 2 for numbers & roles of interviewees)

Public Health within the Course: The delivery planned

5.4.4. Conceptualising and Integrating Public Health within Health Visiting

Learning Public Health: The Curriculum

Public health material appears explicitly in the profession specific module for Public Health Nursing. Within this, as with other applied specialist modules, curriculum documentation suggests that students are assisted to recognise 'the role and

contribution of the specialist nurse in assessing and analysing health needs' and to 'address the demand for collaborative working'. Like the other applied specialist modules, this module contains 72 hours of theory and 78 hours of taught practice, and is assessed as offering a total of 30 credits.

Relevant areas of skill are also addressed within core modules. One such module addresses 'the social context of care.. in relation to nursing practice'. Another places value on the development of 'interactive skills in engaging with individuals, groups and communities'. Further modules address the need for students to respond to [changing] 'social and economic policies' and 'to question practice and propose change'.

One module is a double module which seeks to provide students with the skills required to meet UKCC learning outcomes for the Community Practice Assessment Profile - Health Visiting. It is intended to enable students to 'develop health profiles of communities', to identify and prioritise the 'health related needs of individuals, groups and communities', to plan and activate interventions 'to improve the health of groups and communities', and to 'contribute to strategies and to promote and improve health and prevent disease'. The module is viewed as involving 250 hours of student work, of which about 40% (100 hours) is contact time, with 125 hours in practice based learning and the remainder guided study.

Learning Public Health: Lecturers' Perspectives - What is Delivered

At site 28 it only proved possible to interview one member of the academic staff concerned with the community specialist practice course for health visiting. She was the Route Module Leader for this course at the University. Her background was in health visiting.

Concepts of Public Health, Health Promotion and Primary Health Care

In order to locate their answers within a wider framework, each interviewee was asked to describe their ideas about each of these three concepts. Asked about her ideas of public health, the lecturer at this site said that she saw public health as essentially flexible, and something which set the parameters for people's work. Public health was, in her view:

"a big framework for people to work within that actually encompasses many different types of role."

She went on to indicate that it could operate through community development or organisational management to link with '*the big umbrella of health promotion.*' Health promotion itself she described in terms of a way of working rather than work towards a specified end. She indicated that it would involve helping individuals and groups in:

"making informed choices and also to empower or be advocates for groups of people within the community... so not just .. a one to one partnership but also a partnership with different client groups and a partnership with other voluntary organisations or with other professional groups as well."

This respondent went on to say that she saw health promotion as fundamental to '*community work,*' but '*probably more dominantly in .. health visiting*' because of tradition. Asked about primary health care, the lecturer began from the position that it

was *'a gatekeeper into the NHS.'* She expressed anxiety about the way in which the concept was linked by many people *'to GP practice and therefore the medical model,'* whereas health promotion was based more within *'social empowerment models.'* She felt that primary care groups might offer an opportunity for the two to be more integrated, but went on to comment that it was as yet (February 1999) very early days.

Skills for Public Health

The lecturer was asked to identify the main skills (theoretical and practical) which students might need to acquire for public health practice as health visitors. She responded by listing a range of skills (see table) most of which related to effective interpersonal and interagency working. She said that these were all essential for all practitioners in the community, not just for health visitors.

- communication
- active listening
- interpersonal
- evidence based practice
- empowerment
- facilitating group process
- team roles/networking

The lecturer went on to suggest that the role of the University was *'laying a lot of foundation'* in these areas, rather than consolidating, as she saw consolidation occurring when students were qualified and in practice. Asked which of these skills for public health were covered in the University's programme, the lecturer said that all the skills she had listed - *'all of them'* - were covered. However, she went on to suggest that some of them were covered *'covertly'*:
"When we're running 8 week tutorials first thing on a Monday morning for example then they are practising group processes, interpersonal skills and they are actually running discussion groups and things for each other."
She indicated that team building skills, in relation both to *'the primary health care team'* and collaborative work with clients and others, as well as other areas were *'directly'* taught in one of the core modules. Discussing how far the skills described were taught to other community disciplines, the lecturer indicated that they were not, because *'people come with other baggage'* from prior community experience, whereas the health visiting students were usually moving from *'totally different types of work.'* However, asked whether health visitors were taught more because of their lack of prior community experience, the respondent suggested that in fact this was not the case. Instead, she felt, the level of teaching in these areas was dependent upon individual route module leaders' beliefs:
"I believe in the things we've been talking about so I will push them a great deal whereas perhaps, and I'm not saying this ... but perhaps some of my colleagues aren't that way inclined so much and I don't think some of the others see the public health role in particular as being so important."

Though she saw the University's role as largely in laying foundations which would be consolidated after qualification, asked about the newly qualified practitioners' level of

confidence in using their public health skills, the lecturer said that she felt the students were generally capable:
"[They are] good at finding out about information and networking and collaboration and working in partnership."
Asked specifically about the degree of attention given to collective approaches to public health practice, the lecturer indicated that more attention was given to this area in the second semester of the course, citing specific examples of content which she saw as relevant:
"Then in semester two about a third of the programme because its run continually about things like some of the parenting thats done in R with the buddy system... and in fact theres another session later on and there are other issues around community development, Kate Billingham's work, things like that... so a lot of these community development issues we feed constantly through semester two."
In semester one, there was a limited amount of time for applied practice, much of which was devoted to 'statistics', together with one lecture on 'public health.' Overall in semester two, four hours a week were devoted to applied specialist practice, in which the more collective aspects of public health were raised.

Asked about changes which might be desirable to improve the way in which public health work was addressed in the course, this respondent said that she would like to see an additional module addressing applied specialist practice and integrating theory with practice:
"[A module] actually about them putting it into practice and actually trying them [relevant skills] out would be grand."
She envisaged this being part of developments at the next course validation. She also felt that in practice placements students should be looking more at alternative approaches than was currently the case. In the longer term, she felt that attention should be paid to developing *'Masters or BSc's in public health,'* and questioned the current requirement for health visitors to be nurses, *'though I know I'll be shot down in flames.'* In the meantime she suggested, there should be more joint sessions with other disciplines - for example social workers, GPs and community development workers. The ultimate goal would be to separate out public health work as a specialist area, with a different set of outcomes to be attained.

Asked about the impact of the specialist practice course in relation to public health work with other groups of community practitioners, the lecturer felt that:
"It's brought about much more common sharing and foundation and collaboration."
The main difficulty in doing this effectively she perceived as the limited numbers of nurses from other disciplines attending courses, so that discussions tended to be relatively dominated by health visitor and district nurse students.

Public Health in Practice

The lecturer was asked what sorts of public health activity newly qualified practitioners might be undertaking, and how far the course could prepare them for this. She responded by suggesting that in many of the local Trusts, a relatively restricted role was operating:
"In a lot of the trusts around here there is still that medical model so that what they are employed to do are things like developmental assessments and running baby clinics and you know visiting new mums. Now I'm not demeaning that in any sense of

the word but that is the contractual bit and appears on job descriptions.... They don't see the public health role as being part of the top agenda for health visiting and that is a trust problem."
She went on to indicate that this approach was influenced by GP attitudes. Hence, she felt, many newly qualified practitioners would not have an opportunity to develop less traditional ways of working improving the health of the public.

Barriers and Facilitators to Public Health

This respondent listed two key barriers to public health work in practice. Firstly she suggested that pressures towards the delivery of short term outcomes and cost effectiveness created particular difficulties for public health work where many outcomes might be longer term. Secondly, traditionally oriented contracts and job descriptions acted to restrict practitioners both in developing novel or additional approaches and in prioritising public health work. Looking at factors which she saw as facilitating public health work in practice, the lecturer highlighted the changing policy agenda as constructive. She also felt that practitioners were becoming more aware of public health initiatives across the country and networking with each other on this.

Looking at barriers to teaching public health, the lecturer suggested that the main deficit for her remained in the area of wider integration of this work with other disciplines. She felt that this acted as a barrier to her students gaining a full picture of public health work, since they were not exposed to discussions which built on other disciplines' expertise in identifying and managing health needs - for example in mental health. The main factor facilitating teaching in this area was, again, the shifting policy context and what she perceived as a related increase in media awareness.

Teaching in Practice

At each site, the relationship between the academic institution and those teaching in the field was explored. Asked about how community practice teachers might 'fit into' the teaching, this lecturer responded in terms of study days and opportunities to attend seminars:
"We have study days for the Community Practice Teachers and assessors twice a year, we invite outside speakers for that depending on who they would like to come. That's the first thing. Secondly is the programmes for specialised practice I've given out to Community Practice Teachers as well and if they want to come to any of the identified sessions they can."
The emphasis here appears to be on broad updating rather than more specific educational development or indeed discussion of the course in practice. The opportunities are also at least partially voluntary. When asked to expand on the role of Community Practice Teacher's in teaching about collective approaches to public health, the lecturer's information about the Community Practice Teachers current practice was limited. She was aware that some Community Practice Teacher's had a community development component specified within their job description, but beyond that said 'I hope so', going on to say that the approaches used in practice would vary according to the area served. There did not appear to be any attempt to

ensure that students were exposed to this type of experience consistently, for example by supporting exchanges between Community Practice Teachers, or links to relevant agencies and initiatives. The lecturer went on to say that current uncertainties about preparation for Community Practice Teachers created some difficulty in providing consistency in this area, which she implied was seen as an extra:
"So getting .. these people.. to be convinced they'd like to do this as well, its a knock on bit at the moment."
In general, the lecturer felt there were inadequate opportunities for students to experience collective approaches to public health in practice, exacerbated by what she perceived as a situation where most health visitors were working in isolation and unaware of developments.

Learning Public Health in Practice: Community Practice Teacher Perspectives

Actually Getting Her to See

At this site, interviews were completed with eight Community Practice Teachers (CPTs). Of these, three were individual interviews and the remainder attended a focus group. Though six of the Community Practice Teachers taking part were health visitors, due to some confusion in initial contacts, two of the Community Practice Teachers who took part in the focus group were district nurses. All of the transcripts were extensive, though there were more inaudible sections within the focus group transcript, represented by '???'.

Definitions of Public Health

Clearly it was important to get to grips with how people defined public health. All the respondents were asked 'What are your images and ideas of what public health is?'. Responses fell into three main areas. Some respondents emphasised searching out and describing the health needs of a community or population. Others indicated that action to target health needs was a key part of public health activity. Yet others suggested that public health work involved improving individual awareness about health issues. Some combined one or more of these views. For example one respondent said:
"I see public health as first of all targeting an area using profiling, that sort of thing, and looking at what the health needs of the area are.. You know obviously if you were medically oriented it would be sort of based more sort of on epidemiology, that sort of thing, and once you have established what the health need is then targeting in a group way."

Further comments on this theme highlighted the different types of factors impacting on the health of the public between inner city and rural areas. Another respondent, indicated that 'public health' was different to what she did in her every day health visiting work: *"My idea of public health is really looking at health in a far more global way than the medicalised approaches I would do with the caseload."*
Respondents explicitly compared their notion of public health with a more medical or illness oriented approach, in this case implying that the latter was the approach taken with the caseload. This dichotomy, as we will see later was also found amongst some of the newly qualified practitioners. In addition to raising awareness of health issues,

another respondent suggested that public health related to resources: *"Public health to me is actually improving peoples awareness of health issues and that they have got access to facilities that go to improve their choices in life about health."*
Another dimension on which respondents appeared to look at public health work was the continuum between 'surface' work and 'deep' work, and the way in which public health work involved working across agency boundaries. A focus group respondent added a further dimension, suggesting that the public health role was: *"Political with a small p, things like housing, things like poverty affecting all of those groups."*
She went on to suggest that this vision of public health work might not be shared by some key players: *"That is really strong for me but I don't know whether our employer would see that as public health."*
Another respondent in the group took up the theme, indicating the importance of the wider context: *"It's so much easier now that the concept is out there in the political with a big P... we were all very excited because this is what our job is all about and now.. we're being more valued."*
Where public health work was not recognised several respondents indicated that they had experienced problems with managers and others:
"We didn't feel support at all by other professionals and our management, no, I mean we were being told continually we're an expensive service, what are you doing and is it effective?"
This respondent was highlighting the impact of an increasingly 'evidence based' approach to health care on attitudes to public health work, when relatively little work had been done to establish an appropriate stock of data.

Definitions of Primary Care and Health Promotion

Asked to define primary health care, respondents suggested that it was a key area at present both in terms of policy and in the location of a majority of health care provision: *"The key to all care at the moment in as much as its where the focus of health care is given."*
Taking a classic definition, several suggested that it was the first point of contact which people had with health services: *"Its the sort of first port of call they have."*
One respondent also indicated that primary health care was something which was delivered by teams, involving a wide range of colleagues. Looking at health promotion, respondents suggested that it was an integral part of primary health care. One commented that she was "doing *it all the time'* and said that health promotion work needed to be: *"something that's in everybody's practice rather than just the one day."*
Other respondents indicated that for them health promotion was about teaching, advising, supporting through literature, information. They went on to suggest that health promotion could be visualised as a series of campaigns: *"Every month of the year you know we are supposed to be promoting a particular healthy lifestyle or whatever."*
One of these respondents suggested however that she was: *"Not very interested in health promotion work because I don't think it works."*
Another respondent was critical of the more campaign focused approach, commenting that health promotion was: *"Empowering the individual to take responsibility for their own health rather than giving them a load of leaflets and exhibitions... it is really promoting health with the individual so they can promote it amongst themselves."*

Public Health and Health Promotion in Practice

A wide variety of examples were given in response to the question "Can you give me any examples of public health work that you see going on in your area?" One health visitor described the development of a group looking at behaviour problems in children and indicated that how work of this sort was presented to parents was important:

"It is actually a form of parenting group but we didn't want it to look as though we were teaching people how to parent."

The same respondent went on to say that she and her colleagues had almost all

"..been trained in helping people change, in the health promotion unit and that's enabled us to do one to one and groups."

Another health visitor described a tertiary prevention project her locality had been involved in:

"When people had had sort of minor heart attacks.. when they came out they had whole teams of people that came or visited them regularly, supported them in their dieting and then they were obviously following up to see that it. They had obviously been highlighted as having heart problems but they were obviously trying to prevent them dying from a major heart attack later on."

Many of the examples cited, like this, appeared to be fulfilling the descriptions given of targeting a defined health need. Another such example related to the needs of very young parents:

"We are setting up a teenage health clinic. This has come unfortunately because we have had quite a high influence of teenage pregnancies and what we have identified is that... they don't like coming up to clinic they feel very silly, we asked them what age group they wanted to be involved in there and they said 'Oh well we suppose 12 to 17.' So somebody over 17 was too old to be involved in ???. That is now in the process of being organised and what we are looking at is would be a time when they would actually need to run it themselves but there would be professional input from midwives, health visitors, district nurses, anybody that they feel ... but to bring in sort of issues like looking at drugs, sexual health and all that sort of thing that they would feel happy so that's something else."

Within this example, the professionals are working with teenage mothers to define what is wanted, but also expressing a longer term goal of empowering them to provide support for each other. In another example, of a postnatal group, the more routine development of a response to parents' expressed needs was described:

"We do have a post natal group, we are in the process of slightly changing that ..... in as much as it was just done with exercises and an informal talk and we have decided to sort of actually have a session separate from the exercises so that it's actually a time when we can talk about issues fully and it will be a programme of health issues but not just involving having had a baby. This has come from parents really you know sort of saying 'well they wish they had known more about this and more about that' looking at both behavioural, accident prevention, er life styles as well. Looking at you know ... getting the body back, and looking at the mothers and the family so you know sort of trying to involve the father as well."

In a further example, one respondent described two pieces of work in which she was involved. The first related to tertiary prevention again, focusing on elderly people who had fallen:

"Looking at why is it, because they have got blood pressure problems or other things, to really prevent further accidents and obviously the problems that it causes them. This work appeared to be undertaken with individuals, though with a specifically identified group of people. She went on to talk about work which she was exploring in relation to diabetes - primarily taking an educational approach, and using groups. Group interest meetings for the public rather then professionals, so that we can actually teach that and get rid a lot of the myths about diabetes and about life styles again. You know, why diabetes itself might be sort of increasing, and diet and things like that."

Asked about ways in which public health work might be facilitated in their practice settings, respondents indicated two key areas for change The first was specific time allocated within the working week, even though for many of those responding, public health activity was integral to their practice. They felt that time was needed to build up contacts and to reflect on issues arising from day to day work:
"If you have identified certain services you need time within your working week to do that [follow them up]."
The other important area for change to facilitate public health practice was highlighted as administrative support:
"You know if they would employ a bit more admin staff they would actually be able to release more health visitors."

The Community Practice Teacher and the Learning Process

Community Practice Teachers were asked about the ways in which they had facilitated their students' learning in relation to public health. Whereas the students would suggest that they were frequently controlling learning about public health, the Community Practice Teachers described the difficulties they encountered in helping students to 'see' what it was about. Students' prior knowledge was an important factor in their responses:
"It was very difficult to get her to actually see what public health was because she was much more still, I felt then, in a sort of clinical role, she had come from midwifery and felt that a hands on approach was what was wanted."
The notion of standing back, and getting beyond a 'hands on' approach was seen as important:
"So it was getting her to stand back."
The idea of standing back also indicates a degree of distance from the immediate situation as being important. Public health work was also less 'concrete than many areas where students had previously worked. One respondent indicated that this created difficulties for students in relation to a need for perceived outcomes:
"They often come out I think into health visiting and feel that they are not working if they aren't seen to be doing some task.. I think the problem is that getting across to them that they don't actually have to see 8 patients a day or 10 patients a day or even have an actual recognisable outcome. It might be that you can't actually prove the outcomes overall working in public health .. it's actually long term and I think that's quite difficult for them to see at this stage. I certainly think that I had no idea what my role was like until I really started to work and developed and I think it's still developing now."
This also highlights the fact that roles are not static, and that public health work is changing in response to many drivers. Hence what is learnt will never be definitive.

Previous experience could also act as a facilitator, enabling a student to ask questions which were seen as appropriate. As one respondent said:

"It depends on what she did before.... If the student already has community experience then she does know or have some idea of primary care... for example my student this year was a health visitor's assistant in Z prior to doing the course so she comes into the course with a very, very sort of... global view of people living out there, what it's like for them and she can instantly say, 'Okay there is no working group in this town, is there a working group' you know that sort of thing. If you get somebody straight from a hospital ward you know it's totally different so therefore how do they sort of gear the course to meeting the needs of those people?"

This respondent was rightly highlighting the difficulty of engaging with different levels of experience within the University setting, but did not seem to identify a personal responsibility, as she talked about 'they' rather than 'we'. Another respondent suggested that students recently recruited had lacked life experience in general. As she put it:

"We've been having a lot of the students who haven't got a background."

She went on to explain that these students:

"identify themselves that they didn't have the street cred., because they didn't have, you know, much experience with babies or mothers or other community..."

The notion of 'street cred.' indicates that student practitioners, just like qualified practitioners, need to be able to establish themselves as credible in the settings in which they work. Experience thus could affect their acceptability as much as their learning. A district nurse Community Practice Teacher suggested that in addition, those students who had not been in the community before might initially at least be overloaded with data, and unable to learn, whereas: *"If they've been out in the community before, they might have room for it in their brains."*

Different strategies were seen as bearing fruit in increasing the understanding of individual students of public health work. For example, one respondent suggested that the process of profiling was an important tool for learning: *"I think we worked through it, certainly when she started to do her community profiling, to look at the issues of public health and things like that."*

More pragmatically one respondent described the way in which she sought to enable her student to 'see' public health issues through the use of imagination and scenarios from the local area: *"What I do is I sort of like I asked her to go and look at an area and think you know what does she feel the people have got in that area and identify things that she feels are good about X, what public health issues she could see and then she came back and discussed them and she came back with quite a few sort of like 'Oh well there is no problem living in this area, X is wonderful, you don't even need a bus you know good bus time tables and things' and I said 'Why do you say that' and she said well 'Everything is so close together' but then I pointed out to her 'Can you imagine what it would be like to live .....' I said 'the main estate is something like 2 miles out of the town' and I said 'You have got triplets' which I know we have and I said 'You can't put them in the car erm and there is no bus, would you find that difficult, would you come down into the town?', she then started to look at it so it was actually getting her to see ..... because to her driving around in her car it was very accessible you know well what she felt was it was very close, but walking two and a half miles..."*

Where students came straight from hospital, one respondent, a district nursing Community Practice Teacher, reported an assumption that clients would comply with the student's instructions rather than taking an empowering or participative approach: *"Our student is very interesting, she comes from hospital and she presumed if she told somebody something that was it they would do it and she'd been to see someone with leg ulcers and she came back and said I've told her this and I've told her that and everything else and I said has she... and she oh yes, yes, yes she said, but anyway she was disappointed because she said do you know what, she didn't do anything I that I said."*

Again however, it is unclear where the Community Practice Teacher's guidance comes in to the picture. However, this was not always the case. One respondent indicated that she encouraged students to think through particular public health issues and to undertake self-directed learning to gain confidence. *"I can identify the areas where I can see that there is a public health issue but what I try and do is ..... well what I do do is, I don't tell them anything really I sort of say 'right go off on a fact finding mission' rather than say 'Well this is what public health is' - Let them find out what they think and then how they feel they would like to do that so a lot of their time is spent actually going and talking to people, getting to know clients.. If they facilitate that they can see that they feel confident to do it and get the information."*

This respondent explicitly indicated that she preferred to send students out with a range of colleagues rather than see them undertaking large numbers of 'routine checks'. Another respondent suggested that she had facilitated her students to appreciate the wider health context *"I have trained my girls to make sure that they look at the family's health you know, whether the mum is depressed or the dad's unemployed, whether they can get into services.. I think by the time they get there they might not realise that they are using their public health skills but they are."*

However, it is possible that these relatively non-directive approaches to teaching about public health could be interpreted by a student as lack of knowledge or interest. Another respondent indicated that there were difficulties in just exposing students to a range of agencies: *"When it comes to understanding how other agencies are run they don't understand those unless you actually work beside them, so if you can spend a day within social services you can spend an hour with another agency and a half a morning with another agency you will get the general idea of what they do but you don't work with them do you?"*

However, this respondent did not indicate how she would move from the relatively superficial 'exposure' to a deeper level of learning about interagency work.

Asked about the impact of 'integrated' learning with other disciplines, respondents indicated that they were unsure what this might be. Focus group respondents said: *"We only see them when they come out in their own one discipline."*

Another individual said: *"I don't think it has been as good as they thought it would be."* Another respondent indicated that some problems arose where students had had prior community exposure: *"I don't know if its improved or not, I'm not sure actually. I think particularly, I don't think its helped having CPNs.. there is a lot of animosity.. the CPNs constantly tell you all the public health stuff isn't relevant.. But then that's historical because most people who do that course are already CPNs."*

There was not scope within this study to examine the perspectives of practitioners undertaking a mental health route to specialist community practice.

Skills for Public Health Practice

Respondents were asked to list the skills which they felt were essential in public health work. The attributes and skills which were identified are listed below. The possession of an appropriate knowledge base was felt to be important in giving practitioners confidence to undertake public health work (seen as a more difficult job than 'traditional' health visiting): *"Public health is I think a much harder job than ... than traditional health visiting because you know you have got to obviously be clear about a frame work and that's why a lot of health visitors are frightened of it because we are not always offered some framework to work round."*
A different approach to problems was also seen by some as important: *"Other people in the community tend to still be quite dammed in by the medical side of it whereas the skill of the health visitors is we can be outside of that sort of saying 'Oh you know people have to do it this way' it lets me identify it in a different way so that's one of the skills that I think health visitors certainly have."*

- Academic understanding/knowledge base
- Assertive
- Avoiding a medical model
- Being a good observer
- Challenging
- Communication and interpersonal skills
- Effective multi-agency working
- Good at profiling
- Independent
- Information gathering
- Listening
- Mature
- Open minded, not judgmental
- Planning
- Problem solving
- Think laterally

Of the overall list, two groups of skills were cited by almost everyone. These were communication and interpersonal skills, and information gathering. In relation to communication, practical examples were given: *"I feel part of the training is being able to present, to put things over clearly.. a lot of public health is actually being able to change people's ideas or influence them, the uptake of things, and I think you have got to be quite at communication to get that across especially to GPs, of why it would be beneficial to do such and such a thing, to start up such and such a course when you know quite often you get the answer back 'Well of course you know we have got all these people out of work, we have got all these people with excema we have got all these people doing all these things and why should we pay money to start a behavioural group?'*
This flags up a theme which was seen strongly in the earlier phases of the study - the need to be able to influence and work with GPs. Looking at information gathering skills, the majority of examples were linked to profiling and assembling the information required to undertake public health work, but there was also a strong feeling that students should be able to *use* the information gathered. This led into a

discussion of the ways in which the degree course prepared the students for public health practice.

Asked which skills they feel newly qualified practitioners are most confident with the answer from several respondents related to the basic 'hands on' tasks which most health visitors undertake routinely. These are not strongly 'public health' in type, though: *"I think the hands on things. The things like weighing the babies, doing developments and things like that. There's more of a thing that if they can feel there is a ????? outcome I think they feel very confident but I know that most of the students that I know are quite keen and want to do all the new birth visits and developmental things that - those are the ones that they feel very confident with."*
Another respondent indicated that she placed less emphasis on these areas: *"Some of them say all the others are doing 9 month checks and.. I said you have got years to do that... They can read it in a book you know. So I do far less of that and I feel what they haven't got from me they have got from all sorts of other people.. they are out there to see what is going on in the community, the grass roots."*

Barriers to Public Health Practice

Asked about the barriers in practice to developing effective public health work, one respondent indicated that this was an area in which many people were seeking to operate: *"There's a little bit of everybody is trying to do a little bit instead of saying this is more social work, this is more so and so and it's a little bit like .... although I think the principles of Sure Start and that are very good, you know identifying the people saying 'Oh well look they are going to have these specially trained people that are going to come in and do things' which actually health visitors have been doing at that level for a lot of the time, so I think a lot of the barriers are that you know there is sort of like so much money in the pot - people are going to say 'Well so and so is doing that, that's not really your role' and I think some of the ... I think time constraints as well I mean the ??? are so high that often you are bogged down in doing the sort of everyday case load that you don't have time to sit down and sort of give time to actually what is needed."*

The other strong message which comes through from this respondent is the lack of time for individuals to reflect. Another respondent linked this to getting 'caught up' in traditional work: *"The disappointment is when they come out they are not supported - you know there isn't a role for them in it.. They still get caught up with very.. although I know you can do public health but there is a very traditional framework of health visiting, you know, the kind of under 5s work."*
This respondent suggested that the value placed on work by the Health Authority and the Department of Health mattered in students' perceptions of public health work. She felt that recent shifts in policy had begun to encourage students in developing ideas, and had also begun to impact on the necessary infrastructure to enable practitioners to 'stand back' and reflect.

Preparing for Public Health Practice - The Course

Community Practice Teachers are the people who deliver 50% of any community specialist practice course - the practice-based element.. They were asked about their perceptions of the course as a whole, as a preparation for public health practice. A

number of respondents reflected on the balance between theory and practice within the course. Their concern was that academic, largely theoretical work was prioritised: *"The whole emphasis is on getting their assignments in"* largely at the expense of developing or consolidating practical skills. This, they suggested, could impact on the ability of students to undertake the job which they were being educated for. One respondent for example indicated that essay writing, whilst important in a degree course, was less important to families!

"One of the problems I do have in all the students is actually making them see that the skills they need are the ones they are going to practice out in the community and they don't actually see that as important. You try to get across to them that yes, they obviously need to be able to write an academic essay, but at the end of the day when they are working in X, practically you know the people ..... the clients out there aren't going to care two hoots whether they can write an essay on something, what they want to know is that they can actually access the information and support that they need - and that I think .. isn't explained enough."

A focus group respondent supported this based on her own observation:

"As I was saying, with the clients, the clients could see if they weren't confident in those areas [behaviour management] and you know their own confidence levels."

A number of respondents raised questions about the degree of communication which existed between the Community Practice Teachers and the University running the programme. Comments broadly fell into two groups. Firstly, respondents indicated that they felt that the University did not take enough responsibility for supporting and training Community Practice Teachers to undertake their role. One Community Practice Teacher in particular felt that she lacked an appropriate knowledge base, though she was seeking to remedy this by study elsewhere. She said:

"I don't think they take enough responsibility for supporting and training of Community Practice Teachers... I don't think I have had a good training. You know I did my course, I did my Community Practice Teacher course - we have these three days in a year that we are supposed to have to keep us updated which is useless. I think the lecturers think its just a day - another free day really - we do very very little."

The perceived focus on updating was picked up by other respondents who indicated that the University did not spend enough time in communicating with Community Practice Teachers about the learning needs of students, or indeed the curriculum which was being delivered in the University setting. One said: *"They don't give me any guidance other than learning outcomes."*

Another respondent said: *"I think the colleges need to come out to talk more with the community practice teachers. I feel it's very poor you know they don't give us any ideas really of what they are teaching them in the course. I mean even when we have Community Practice Teacher study days they don't talk about what they are doing with the students it's much more of just updating others really often to me it seems a waste of time."*

To some extent the gap seemed to be in interpreting the documentation provided and taking responsibility for facilitating learning. One respondent said however that public health formed only a relatively small part of the totality of the remit of the Community Practice Teacher.

"I have to try and address all the modules she is given and all her learning outcomes. The public health aspect of the learning outcomes is very small, you know."

Another respondent indicated that although she did not feel that documentation was adequate as a guide to what she should be doing, she developed her own approaches:
"I read all their assignments and I try and - whatever they are learning here I try and integrate it into you know what assignment they are doing at the time."

Other Community Practice Teachers were critical of the University staff, as not being in touch with practice. One felt that *"the standard of teaching [was] poor."* Another suggested that the lecturers were learning as much as the students, especially in the area of public health:
"The lecturers on the public health pathway, that's where, without being too judgmental, I feel that they are seeking and searching themselves, how do they know? You know they've come from a background of where they've been doing for a long time the same sort of thing. You know, but the programme changes but they haven't had a chance to catch up themselves."
This respondent went on to say that she had an appropriate knowledge base, but was unsure of her capacity to convey it to others appropriately: *"I do have the knowledge but I mightn't have the academic sort of tools to convey that within the University setting."*
Feelings of inadequacy or at least lack of appropriate preparation in fulfilling the current role were expressed by several respondents. In addition to the respondent mentioned above, another commented: *"I have not done any study other than my health visitor course"* and another said that there was now *"an emphasis from [managers] on getting our degrees."*
One respondent felt that she was therefore led largely by *"what other people suggest"* in her management of the student's experience. One particular issue in relation to the preparation of Community Practice Teachers to teach about public health work was highlighted by one Community Practice Teacher working part-time in a community development post. She said that the University required her to have *"at least two and a half days in a caseload"* yet this impinged on her capacity to carry out public health work effectively. Other respondents felt that concentration on *"bog standard individualistic health visiting"* limited their capacity to teach about or indeed undertake public health practice.

Respondents highlighted ways in which teaching about public health could be improved. All respondents indicated that more time would be an asset to the development of their teaching and practice in public health:
"The barriers are having too big a caseload, having too much responsibility, you need special time to develop that and when I say time I mean time to reflect, to think what you are doing, time to discover."
Several respondents indicated that they did not have any lower caseloads than their colleagues, instead carrying additional responsibilities which amounted to a higher workload. However, some Community Practice Teachers were working on ways of coping with this and with the shortcomings they perceived in existing structures. Some had already grouped together to develop more effective teaching about public health work: *"In fact there is a group of us who felt very much let down by the college in as much as they had not been and talked to us and we are actually looking at what we can do to change the practice within the community about public health, I think, on those areas."*
Another respondent suggested that if students had a specifically focused public health assignment, they might learn more about the way in which theories and frameworks

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applied in practice. *"I feel that it would be quite good if there was a part of the course that was identified as the student had to do something with the Community Practice Teacher on a public health issue.. but instead of it having to be an academically assessed it would be ... practically so.. I think it's an opportunity that they have to give it for it to work.. wholly you know specifically public health."*
In addition, respondents indicated that they were seeking to get students not only to gather data about the incidence of particular problems in the community, but also to ask themselves *why* these problems occurred.

Learning and Doing Public Health Work: Health Visiting and Public Health in the Field

'Standing at the Deep End' - The Students' View

Interviews were completed with five people who had undertaken the public health nursing option of the specialist practitioner course provided at this site in the past year. Two were individual interviews and three attended a focus group. The quality of the focus group tape appeared to deteriorate during the interview so that relatively little of the later section of the interview can be fully transcribed. Field notes taken at the time were limited and add little illumination.

Definitions of Public Health

Each participant was first asked to define public health. Their responses reflected a somewhat confused picture - as one respondent said: *"It means different things to different people.. people with a medical background public health means targeting diseases - immunisation and things like that and someone coming from a different background its a philosophy 28pfg/2."*

There appeared to be agreement that public health related to a bigger unit than the individual, and that identification of health needs was a central component. For example, one respondent said that for her public health work was: *"Working in a way other than the individual one to one tackling health problems 28pfg/2"* whilst another said it was *"Looking at the health needs of the practice population 28n12/1"* or, as another respondent put it, *"Reaching out to the public to meet their health needs 28n10/1."*

However, some respondents indicated that public health was a distinct area of practice whilst others suggested that it permeated all their work. One respondent for example indicated that public health work took the form of discrete 'projects':
"[It] starts by identifying what health needs there are.. and working on them to develop projects 28pfg/2" whilst another highlighted the uncertainty of other health visitors about what it might be: *"Some health visitors will say 'well I am doing public health now anyway, I am involved in immunisation' whereas other health visitors will say 'well no actually I don't do that really' but it is public health but it means more than that.. 28pfg/3."*

Asked about their own examples of public health work, respondents indicated that they did differentiate 'public health' work from 'routine' health visiting practice, though for some the boundary was perhaps less clear: *"For example doing a stand in*

Boots, doing a talk about some ?? to - setting up a class stopping smoking in the surgery which is practice based - to something like post natal support groups is public health, its promoting of that population in that area. You could probably read that into almost anything I do actually 28n10/2."

All the examples given here relate to group-based activity, though this respondent suggests that almost anything she does may qualify, and later reiterates the point:
"All antenatals get a visit. I try and research out the health needs from that point of view and then the developmental checks of course.. and of course primary visits.."
"This sort of work, would you describe that as public health work?"
"Yes I would because they are part of the public."
Another respondent makes a much clearer distinction, and relates it also to her stage of development as a practitioner: *"Because I am relatively new to post [about 8 weeks] I actually have to get used to working with my caseload before - and working out the health needs of the area - before extending into a public health role. 28n12/1."*
The Community Practice Teachers also picked up the notion of a developmental trajectory in relation to public health work.

Definitions of Primary Health Care and Health Promotion

As well as examining practitioners' perceptions of public health, two linked concepts were explored by the research team in order to distinguish how far they might overlap with or influence their ideas about public health. The first of these ideas to be explored was 'primary health care'. Respondents varied in how they described this, from one who suggested it was essentially a venue for care: *"Its like a pit stop really.. and where we tend to care for most people out in the community 28n10/1"* to another who explicitly saw public health as falling within a wider concept, relating it to the World Health Organisation's Alma Ata Declaration: *"Public health should be part of primary health care.. [it goes] back to the World Health Organisation Declaration 28pfg/3."* Another respondent commented that primary health care was changing its focus: *"Now, instead of looking in a disease focused service we are looking at prevention, so primary health care is sort of - in the community the prevention of ill health 28n12/2."*

The second important idea to be explored was that of 'health promotion'. Here a distinction was drawn between a 'medical' approach to health promotion and other approaches, though there did not seem to be much consensus about what the latter might be. One respondent suggested that health promotion was essentially about information giving: *"If you are from a medical background it means talking about lifestyle changes.. to me its giving information.. [to] the community 28pfg/4."*
Another respondent indicated a rather wider conceptualisation: *"Promoting health. Maintaining positive health and well being which might not necessarily be the answer to disease. It includes things like psychological and emotional well being which is slightly different to the medical profession which perhaps uses illness as - as sort of to treat illness as opposed to maintaining well being. 28n12/2."*

Again, respondents explicitly indicated a degree of confusion about definitions. Health promotion work was described in terms of screening and meeting individual needs:

"The health visitor's role offering the over 75 elderly screening check, within that what we did was, we offered clients when they arrived at the surgery the opportunity to identify any areas that they would like the chance to talk about and people wanted to discuss mobility for instance, other people wanted to know what aids there were that they could use in their homes to make life easier you know.. or people brought up the fact that they were lonely and spending a lot of time on their own so we put them in contact with lunch clubs and things like that. 28n10/2."

Skills for Public Health

Respondents were asked what skills they felt were needed to undertake public health work. There was rather more consensus about this than in looking at what public health work was, with all respondents agreeing that communication was 'most definitely' a key public health skill. In addition respondents agreed that health needs assessment was important. One added that skills were needed in handling statistics:
"You need to know how to go about doing health needs assessments so you need to – fasten on to the next thing – statistics – where to get these statistics from, how to use them and compile them to demonstrate the health needs of the area 28n12/2."
Another respondent talked about 'profiling' - a similar process - and highlighted the importance of team co-operation in this:
"Practice population profiling – and you need co-operation of the primary health care team in order to address it because I found that to be a problem. 28n10/2."
Finally one respondent highlighted the importance of *"group work facilitation skills."*

What was taught? – Learning to swim

Respondents were asked which of the areas of knowledge and skill they had described were covered on their course, and who taught them these. Much of the teaching which these practitioners recalled appeared to be 'theory' rather than 'practice':
"From the university, that was very much the theory part of the thing, [it] was looking at different models of health assessment and.. I can't think what else we did.. we did some work on group work. That was more of the theory side of things, we didn't really do facilitating groups. 28n12/3."
This respondent went on to suggest that Community Practice Teachers (CPTs) focused primarily on teaching about what is sometimes called 'bread and butter' health visiting – the developmental assessments and more 'routine' work (if health visiting can ever be called routine – Cowley 1995):
"I think a lot of the time we felt that the practice component of the course was, for the Community Practice Teachers, that was all about the routine and child health surveillance. 28n12/3."
She identified deficits in the curriculum in terms of 'setting up and running groups', and 'how to access funding', as well as setting up a 'service definition'. She had sought out information on this last:
"I have got the information on how to do that now but I wasn't given it sort of during the course. I got that from the CPHVA. 28n12/5."

Another respondent indicated more about the self directed type of learning which the course encouraged:

"They heightened our awareness that there may be a problem [in recognition of a wider health visiting role] but – didn't really give you sort of this is how you address it. I think it was – they taught a lot of 'you have to be creative in how you get round that and to use your professionalism and your communication skills in order to get that across' 28n10/2."

Asked about areas in which she felt less well prepared by the course, this respondent indicated that it was in practical situations which she was meeting – but added *"no university could prepare you for that."* She was, she said, using her *"creativity in getting around the corners. I am working on my own in a single handed practice so suddenly coming out of university and doing that – it's a case of – sometimes I feel like you are standing at the deep end, you don't know how deep the water is but you have got to jump in anyway because there is no-one else to do it."* 28n10/3.

Asked about the skills she was using in that situation, this respondent went on to indicate that these centred on risk management:

"I think its judgement skills isn't it, its sort of trying to weigh up the situation thinking you know can I do this on my own, what hazards are ahead, what can I foresee happening if I do x, y, z and do I need assistance in this or can I go ahead and do it by myself, so its those sort of skills of assessment really." 28n10/3.

Respondents were asked to say how confident they felt about the public health work they did at present, and what barriers existed to their practice in this area. This highlighted again the distinction between those who saw public health as an integral part of their work, and those who saw it as a distinct entity. One respondent said that she felt:

"Most confident with new birth visits, the normal hum drum of developmental checks and all those sort of routine things and I have had a lot of sleep problems so I feel quite au fait with those." 28n10/4.

She felt that she did *'public health work every day'*. The barriers which this respondent said that she encountered were 'a fear of personal ignorance', and problems in attaining the co-operation of the team. This might suggest inadequate awareness of interdisciplinary working. However, the same respondent later indicated that the course *"Was quite heavily focused in multi-disciplinary approaches to the same problems so working with – you know – with other disciplines to meet the same needs."* 28n10/5.

She went on to say that she had visited many different disciplines whilst with her Community Practice Teacher, and asked questions about how their work might be integrated with hers: *"Everything from housing officers and social workers to CPNs and during my time with them for half a day or a day I have said how would you envisage working with a health visitor on this or that problem or where do you see my role as a health visitor in your job – figuring out where the links would meet really ... It was a new approach to me from what I had done in the past – sort of as a nurse and a midwife before and it had always been sort of stick to your own, don't trust other disciplines!"* 28n10/5.

Teaching and learning strategies, as well as the impact of prior experience will be addressed further in relation to the Community Practice Teachers views, but questions arise as to the depth of learning which may be going on in this instance.

Another respondent said that she did a 'very minimal' amount of public health work at present. She suggested that 'routine child health surveillance' dominated her day-to-day practice: *"In an ideal world we would all like to work differently I think but at*

the end of the day there are things that you have to get done and the routine child health surveillance is the thing that takes priority." 28n12/6.
Primarily, she indicated, this was due to its time-consuming nature, and the need for time to undertake work which she defined as 'public health work': *"You need time – to set time aside in order to liaise with other professionals. I have been attending social services meetings, some things like that to try and work with them."* 28n12/7.
This respondent asked, rhetorically, whether she might at present be rather less efficient than she would become in future: *"There is a health visitor's assistant who is able to do a lot of the routine child health surveillance which does enable me more time to do other work but – the size of the caseload still means that you spend – perhaps I am not managing my time as effectively as somebody who has been in the post for say 10 years or whatever? You know its always difficult to balance whether there would be more time to do more public health work."* 28n12/7.
She went on to highlight the time required to undertake the quite complex activities which for her were 'public health work': *"It's the bureaucracy of things as well. Its like finding a venue and then once you have got the venue then its organising the time and then you have to have colleagues ready to sort of, if you are not there to take the group you have to have some sort of back up, and then you know sort of disseminating the information to your group."* 28n12/8.

Asked how far collective approaches to public health such as community development had featured in the course, this respondent said that it had featured within the specialist module on public health nursing. She suggests also that some students, including herself, had actively sought out appropriate experience – for example in alternative practice placements, but also during time with the Community Practice Teacher: *"Her caseload and the work that she did she didn't do any public health work at all, I went elsewhere to get that experience because I identified that I wasn't going to get it with her. I went to X to work with the community development workers."* 28n12/11.

Summary of Health Visitors' Public Health Critical Incident Logs

All health visitors were asked to give examples of work which they had undertaken or were currently involved in which could be construed as 'public health practice'. Fourteen examples were listed by eight participants (see Appendix Four). These ranged from work to introduce a scheme to loan safety equipment to young families, through work on positive parenting to plans to set up a menopause clinic and plans. It is not always clear from the written records what sort of assessment of need preceded the decision to work on an initiative. In some cases it is implicit in the outcomes used:
'HAS ANYTHING CHANGED?
Yes - increased uptake of safety equipment, decreased accidents reported in A&E'
In some cases the work concerned has involved a lengthy process of discussion or planning - indeed in half of the examples given, this is all that has happened to date. In many cases, the intervention or the planning for it has involved other disciplines or agencies:
'Working party group meetings were arranged to discuss the project [a domestic violence phone advice line], including health visitors and other members of the multidisciplinary team (eg youth club, women's refuge workers etc)'
Of the ten examples given, five are still at the beginning. For the remaining five, the outcomes indicated appear mainly to be relatively 'soft'. For example, the changes

which had resulted from a group looking at the promotion of healthier diets were not quantified, nor was there any indication whether change was becoming established:
'A few parents have tried recipes available. Some gained new ideas.'
Evaluation of outcomes was also not sustained over time, as respondents pointed out:
'Short term results seemed good - but no follow-up long term.'

Looking at factors which were seen as helping or hindering the practitioner in undertaking this public health work, positive factors listed included working with voluntary agencies, support from GPs, and availability of money and / or facilities. Lack of time or money, and failure to use local profiles effectively were seen as factors which acted to hinder public health work. One respondent drew on her experience outside the NHS in highlighting fund-raising difficulties:
'In the past I have worked in the voluntary sector, where part of my remit was fund-raising. Therefore, once a need was identified, funds were therefore found to move the project on - as this is not seen as normal practice in health visiting (nor are we trained) - fund-raising can be a problem - and this can prevent or delay projects.'
Another indicated that work in an unfamiliar setting could be hindered by lack of background information:
[In a workplace context] 'Not knowing anyone's background health profile, attitudes might have hindered.'
However, demands for 'time' were sometimes also demands for money - where for example the barrier to progress was seen as:
'Senior management not being sure whether money to pay for extra health visitor hours. Cannot get off the ground without funding for extra health visitor hours.'
Whilst some respondents (most who had clear outcomes) had initiated work from their existing resources, others, as in this case, felt that 'new' time was needed.

Public Health Networks

Respondents were asked to fill in a chart showing the range of people with whom they worked 'to promote the health of the public'. At this site, eight health visitors completed a chart (see Appendix --). A wide variety of colleagues were mentioned across all the charts, ranging from *'members of the community I work in'* to GPs. Workers in a range of voluntary organisations, social workers, housing staff and other primary care colleagues were also frequently mentioned. The reasons for working collaboratively appeared to fall into three categories. In some cases, colleagues could assist in ***identifying health needs*** at one level or another:
Wardens of local sheltered housing: *'I am working with them to identify health promotion needs in their clients so that I can then develop appropriate groups'*
In another group were colleagues who might not only make referrals, but also work with the health visitor concerned in ***meeting health needs***:
Midwife: *'Regular liaison re new mothers or pregnant mothers who are being transferred to care of health visitor. Also joint antenatal classes'.*
However, this required some degree of interest from the professional concerned.
GPs: *'I try to work with GPs but not really interested'*
The third type of collaborative work appeared to be ***'preparatory'*** - work towards some future engagement in action. This could be with one agency - for example the Meet a Mum Association:
'At the moment working together has only meant referring mothers to MAMA and meeting MAMA volunteers to learn about our roles.'

Equally, in some cases collaboration of this type was multi-agency - as for example in the case of a working party to set up a domestic violence advice line, involving preparatory engagement with a number of agencies' representatives.

Public Health Work in Context:

In order to obtain a more widely balanced view of the way in which public health work by community specialist practitioners might be viewed in site 28, four other perspectives were explored. Interviews were carried out with the Director of Public Health (a doctor), from the Health Authority, and the Professional Leader, a Deputy General Manager and a Control of Infection Specialist Nurse from local Trusts.

The Director of Public Health

The Director of Public Health worked in a large local Health Authority spanning several Trust areas. He defined public health as *'about interventions on a population scale'*, and indicated that primary health care was not only a setting where services might be delivered, but also *'uniquely placed to monitor, at a very practical level, [the health of] a population'*. Asked about health visitors, he indicated that he saw their role as based within an outdated paradigm:
I think they are probably measuring up to a sort of practice which was developed in the early part of this century and really became out of date 20 years ago.
Instead, he suggested, they should have:
Skills that are useful in looking at whole populations and less emphasis on dealing with individual clinical situations
Their preparation should therefore include skills in the recognition and understanding of the determinants of ill-health, its manifestations and ways in which it could be managed on a population basis. Important skills to develop would therefore include analytical skills, community development skills - *'how to motivate and mobilise a community'*, and communication skills. He felt that though many health visitors were happy seeing themselves as case-workers, they lacked skills in dealing with, for example, emotional and behavioural problems, and tended to have a more superficial set of skills - *'kind of public safety type messages'*.

Asked about current preparation for specialist practice, he said that he was unclear what this entailed, but felt that:
Their emphasis on the normal and abnormal child actually works against having a good public health perspective... Its not interpreted broadly enough - it is seen almost as a sort of quasi clinical specialty which it isn't, shouldn't be..
Asked to expand on this, this respondent indicated that he felt many health visitors were *'fixated'* with individual abnormality rather than looking at what impact they might have on a population level. Nevertheless, he felt that they could have a *'pivotal role'* in a move to *'the new public health'*:
It goes beyond merely health promotion .. it is to do with providing a sort of focus at a primary care level for all public health activities, becoming responsible in a way that clinicians like the other nurses and GPs and local authority and voluntary workers don't.
At present he believed, the curriculum which they followed *'leaned them'* towards child health. In addition he perceived a lack of continuing professional development

opportunities locally. He described his impression of health visitors consolidating practice, and suggested an alternative scenario:
The first couple of years they develop you know a kind of script which is about how you deal with families when you go on the door, at day 14 you've got your own little way of working and I think.. you quickly lose the opportunity to break out of the script and think a bit more widely, and that could be done if there was really quite an intensive effort to support them for, what, the first 5 years.

He indicated that there was at present no-one clearly leading 'the public health community' because for example Directors of Public Health like himself had focused on:
Our clinical epidemiology role... the evaluation of health services and rather hard-nosed advice on what works and what doesn't work
However, he suggested that the new policy direction should enable him and his colleagues to become '*more visible*' and among other things, '*very specifically [to] help health visitors free themselves of the bind they've got into*'. At the same time, he suggested, many '*contemporary health visitors*' might not like working in a new way, as it was not '*what they came into health visiting for*'. Much health visiting, he said, was '*insular, inward looking*'. Nevertheless, despite this, he said that he had met health visitors who were:
In effect public health beacons, but I get the impression that that is not what they were trained to do and they have this kind of subversive look to them, and if they're not properly doing their job, they're doing another job.
He suggested that those whom he could recognise as carrying out a public health role were working in inner city areas and that the role taken by the others might be:
'because there isn't starkly in front of them a public health job to do'

The Professional Leader's View

The professional leader interviewed at this site had a background in district nursing. This was evident in her thinking, though she gave examples from health visiting as well. Her main remit appeared to relate to standard setting for community specialist practitioners within the Trust. She was also the lead person on education for the Community Directorate.

Defining Public Health and Health Promotion

This respondent appeared to identify public health work with campaign based work (for example on smoking and heart disease) and work with groups, differentiating health promotion as focusing on 'individuals in their own homes'. She felt that time was a crucial element in health promotion work: *"I mean you can hand out leaflets but whether its read or not - you know you need to spend some time explaining and reviewing it."* She expressed some uncertainty about the responses of clients and patients to information: *"They might test us out on issues relating to [a particular topic]."*
Following this up she suggested that community practitioners should not expect to be 'experts' in every area. However, she also highlighted the importance of remaining up to date in terms of research and seeking to use research in practice.

Public Health Work in Practice

Asked to give examples of what she would call public health work, this respondent indicated that she predominantly thought of groups, but also considered screening activity. She cited one specific example of a well women's group meeting at a local hospital initiated by health visitors locally. More generally she commented that public health work should: *"begin to impact on well people to promote wellness before illness happens really."* She indicated that monitoring the health of people over 75 was 'primary care work' but: *"Whether that's really an issue of public health that's debatable isn't it?"* She described health promotion activity in terms of information giving and indicated that health visitors had in her view better opportunities for this because they delivered *"one to one care"* themselves rather than delegating it to others, as was in her view largely the case for district nurses.

Skills for Public Health Work

Certain skills might be seen as requirements to undertake public health work. This respondent highlighted as core, communication skills and the ability to listen as well as skills in observation and assessment. She placed considerable importance on the ability to discriminate appropriately when to give or not to give information and to locate advice and information in the context of what was important for the individual:
"Clearly sometimes it would not be appropriate to give a lot of information about health promotion.. If you've got somebody who's stressed and unemployed, all these sorts of things, although we know that smoking is bad for your health, if that's the thing that's relieving their stress then it clearly might be inappropriate to go on about stopping smoking.. you've got to be sensitive to individual clients."
This response perhaps indicates a relatively unsophisticated model of the factors involved and ways of intervening to change individual behaviour.

The Course

This individual's response in relation to how far the course provided appropriate preparation for a public health role appeared to be relatively superficial. She had not herself been a Community Practice Teacher and appeared to be commenting from a slight distance:
"They have quite a lot of information about working with people and ... the course itself does offer an opportunity to cover most of the skills you would need .. it is 50% taught and 50% theory and you would expect that they would be learning while they're in practice as well and identifying some skills with their Community Practice Teacher that they may not recognise through reflective practice."
She re-emphasised the importance of reflective practice when she talked about 'unpicking situations that didn't go so well', and indicated that the course did address different approaches to health promotion: *"I think they do look at health promotion within the programme and the different approaches to health promotion, the impact that different approaches might have."*
She felt that newly qualified practitioners were most confident with individual communication skills, mainly because they were quickly consolidated in everyday practice. Focusing on work with groups she suggested that: *"Health visitor students that I've been involved in, they do find group work particularly worrisome until they're used to you know standing up and talking to a number of people."*

Asked whether there was a gap between the skills gained on the educational programme and the skills needed to fulfil a public health role, this respondent said that if such a gap existed it related to the opportunity to practice, review where they were and make changes. Differentiating between programmes at two local Universities she went on to suggest that there were benefits in this area because one course had retained a period of supervised practice: *"There are more opportunities to get more confident than on some of the courses when they don't have supervised practice, and I understand that [X University] are fairly unique in offering supervised practice still."*

This respondent indicated that students were *'really responsible for determining their own [learning] needs'*, and that it was then up to the Community Practice Teacher to seek to meet those needs by negotiating appropriate opportunities. She suggested that the importance placed by University staff on public health work would affect learning in this area, and mentioned that the route module leader for the public health route was currently: *"Shadowing me.. and she's actually working with the school nurses and the health visitors and issues in child protection..."*

The Practice Environment

Asked about what newly qualified practitioners did day to day in public health, and how the practice environment affected them, this respondent indicated that they did *"not as much as you might wish them to do."* She indicated that this was because (across the board) community practitioners were very busy and *"health promotional activities get squeezed out,"* but that she had been surprised, in a recent survey, that there was a lack of recognition of this type of activity even amongst health visitors:

"Obviously the staff don't recognise that they're doing a fantastic amount.. but that's maybe the way that they felt they were being asked to record the data."

The barriers which this respondent identified were the numbers of clients requiring to be seen 'in a given time', the need to prioritise other types of work and also lack of continuity to build an adequate picture of impact. Factors facilitating public health work included opportunities for regular review, developing structures for clinical supervision and the development of multi-professional forums to discuss public health work.

The Deputy General Manager

The Deputy General Manager worked in a largely urban Trust linked to the Site 28 University, and was responsible for managing health visiting services. Asked what public health meant to her, she appeared to describe it largely in terms of a collaborative approach:

They [health visitors] go out there and work on their own, form groups, but they can't do it alone, they have got to do it with housing, they have got to do it with social services, they have got to do it with the voluntary advising agencies etc. because they just won't be able to move it on, and they have got to do it with the public.

Examples of what this might mean in practice included a health visitor working mainly with Somalian refugees, focusing on facilitating access to health provision.

Whilst she felt that many GPs had previously failed to acknowledge or value health visiting, she suggested that movements towards Primary Care Groups had generated a recognition of the potential of health visitors 'to help them with the health need

profiling of their areas'. She suggested that education programmes needed to provide more in this area:

I know they are supposed to learn that.. but I think its got to be reinforced because once they start getting into their caseload and going to the universal screening and things like that.. they don't always actually lift their heads up and look at the real needs of the population.

In addition, she listed a number of other skills which health visitors should develop, including marketing what they find, research based practice, influencing purchasers/ GPs in Primary Care Groups, interagency working - skills in collaboration - and assertiveness. She emphasised the need to develop skills in collaboration saying that health visitors were '*not team players most of them*' and required encouragement to work collaboratively. In the practice setting this respondent saw herself as having a role in facilitating a collaborative approach. She highlighted difficulties for students emerging into practice in '*turning theory into practice*' and suggested that '*universities and colleges are still lecturing the ideal and not the reality*'. She sought to redress this when meeting newly qualified health visitors. Whilst acknowledging that she was not abreast of current course developments, she said that the focus of the health visiting course appeared to have changed:

Now I hear so often its the under 5s or the under 4s that health visiting is going for I am wondering if the colleges and universities are aiming at just this child group, under 4s, under 5s before they go to school, and not looking at the family any more?

She felt out of touch with educational issues, but said that there had been fewer health visiting students sponsored of late, a situation which she perceived as rooted partly in national trends, and partly in responses to the integrated community specialist course:

We had much, much fewer health visitors who wanted to be working with the elderly population - when it became a more co-ordinated training, isn't it with district nurses, the integrated one?

She felt that the trend had now begun to reverse.

As a manager, she said, she wanted to see a wider focus for practice:

I think we spend far too much time doing universal screening on children... How can any one expect health visiting to do a public health role when they are spending 90% of their time ... doing all those developmentals...

Challenged as to whether she had any influence on this situation, this respondent said that she did, but that contracts with the health authority set out service specifications which tended to bog down health visitors '*as if it is written in tablets of stone*'. She felt that health visitors should suggest alternative programmes to meet local needs, particularly if they were educated appropriately in targeting and setting short and medium term outcomes. She suggested that newly qualified practitioners going into areas where there was innovative and exciting practice and '*a good team environment*' would learn very quickly about local needs. These were often areas where there was considerable deprivation. Unconsciously echoing the views of the Director of Public Health this respondent said:

I manage an inner city and I am always looking for fresh new health visitors so I think its a good environment, so long as I know that they are being supported. I think they come off better actually than going into some of these rural areas and you know, finding it out for themselves really.

Asked whether any of the newly qualified group were working in posts with an explicit public health component, the manager said:

I don't think they do, I think its the ones who have been trained for a while and are more experienced and that's - actually ... that's a shame isn't it

The barriers which this Trust manager perceived to establishing and maintaining public health practice were firstly, lack of recognition - by GPs and managers, and secondly, service specifications in which there is no mention of public health. Factors facilitating public health practice included giving '*permission*' to health visitors to do it, and providing them with relevant education and meaningful information.

The Control of Infection Nurse Specialist

The third perspective to be explored was that of the Community Control of Infection Nurse Specialist within the Health Authority at site 28. This Nurse was recommended for interview by another contact as someone within the Authority with a clear understanding of public health roles in nursing. Her definition of public health related to the control of communicable diseases such as TB, hepatitis and meningitis. Primary health care was defined as:
Health care that's delivered to the client that's totally devoid from secondary medicine.
It emerged that this respondent was not herself a community nurse but had trained in a hospital setting in infection control. This appeared to be influential in her responses. She saw communication skills as a central component of public health nursing work. In addition she suggested that nurses would require adequate grounding in different clinical conditions which they might meet, and awareness of cultural issues which might be relevant. This specialist nurse found that she advised many community practitioners, seeking to ensure they were well informed and giving similar information to clients. However, she had little idea of their educational preparation and could not say what might be required in other aspects of their work.

5.6. Summary

This chapter has set out in some detail the findings of the four cases explored in Strand Three of the study. At each site, data was gathered using focus groups and individual interviews as well as public health incident logs, curriculum documents and local policy documents. The data gathered looked at respondents perceptions of public health, the nature of the educational experience of the students in relation to public health, and the way in which this was translated into practice, together with the factors which acted as barriers or levers in the latter. At all sites, respondents found it difficult to articulate what public health work might be, though all the practitioners provided examples of public health practice in the logs. The balance between University based work and learning in practice was seen as important, with the models of public health available in the practice setting seen as central to learning. Community Practice Teachers were seen as a key influence on students' practice, but in their own practice struggled to balance public health work with other responsibilities. Public health work was seen by them as 'add-on' work, not highly valued by colleagues and managers. Time was seen as a major constraint to effective learning.

CHAPTER SIX

6. EMERGING THEMES

This chapter describes the overarching themes emerging from the data presented in Chapter Five. In particular, it sets out a cross-case analysis of the data looking at concepts of public health, perceptions of public health practice, factors acting as hurdles or levers in learning about public health and developing public health work, and the education process itself. A tentative model of the process of learning about public health work is described.

6.1 A Cross-Case Analysis

Four sites were initially chosen in order to explore issues for each of the three community specialist programmes at two sites, and to gain some understanding of how far a shared programme might impact on students' learning and outcomes in practice. Having in the previous chapter considered the data gathered and analysed at each site, this chapter looks at common themes and areas of contrast across the data. Table 3 sets out some of the key areas for the four case sites, looking first at conceptualisation of public health, then at factors described as barriers or facilitators in the learning process or in practice, and finally at specific issues in the education process.

It is important to note the limitations of analyses for individual case sites described above - resulting for example from the small numbers of practice nurse respondents at site 15, and the failure to engage with the health authority perspective at site 32. Though participation rates within each site were lower than hoped for, in most cases the range of participants envisaged was obtained and a variety of views described. Whilst there is likely to be some impact in the range of concepts which can be uncovered and the depth of analysis which can be achieved, within each site, exploration of issues and ideas from different perspectives provides a firmer base to work from. In this section, consideration of common themes and areas of contrast across all four sites suggests concepts within the data which are more secure.

	Multidisciplinary	Practice nursing	District nursing	Health visiting
Concepts of public health	• Lecturers find these easy to articulate • HVs community / population • PN/DN Individual / health promotion / illness prevention	• Lecturers prioritise environment / holistic • Practitioners is public health work just expanded PN roles?	• Changing role important for DN • Continuum from empowerment to hygiene	• Practitioners - some confusion on details but clearly collective • Based on principles of health visiting • Commissioners poor understanding
Hurdles and levers	• Clear ideas facilitate change • Structural barriers • Managers not valuing work • Balancing legitimate v. fringe	• Time for bread and butter practice. • Need for training • Need for information systems.	• Reflection central to integration. • Colleagues' attitudes • Lecturers' lack of clinical credibility • Pressure to 'hands on'	• Policy shifts positive • Number of players with overlapping roles • Pressure towards 'hands on' practice
The education process	• CPTs as bridge between theory and practice	• Doctors produce diversity • Curriculum prioritises networking, information management, reflective time	• Idea of the course transforming perspectives.	• Theory is recalled not practice. • Role of CPTs to help students see how it links in to practice.

Table 3. Key areas for public health practice by case-study site.

6.2. Concepts of Public Health

In order to locate each respondent's discussion of public health work within the framework used by the study team, each was asked to outline their concept of 'public health'. This proved to be a challenge for almost all respondents, with only lecturers experiencing relatively little problem in articulating what public health might be. Overall, responses fell across two dimensions (see Figure 7). In describing their own concepts of public health respondents often used words like community, population, or collective. In contrast they described other people as holding narrower views of what public health was - often labelled as 'medicalised'. Some respondents indicated that they thought of public health in terms of infection control and immunisations, others that it involved a broader spectrum of health promotion, searching out health needs, and still others that it was primarily about the empowerment of communities and their development.

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Public health actually I'm thinking is like environmental health came to my mind first of all, erm yeah I mean I suppose it means how the public are, I suppose the Government are much more into that at the moment. CPTDN32

The public health role for me is looking at the area or the practice area that I work for. Looking at the health needs of the practice population. HV281

Health visitors at both sites indicated that they used a collective model. Many indicated that this was based on the principles of health visiting (CETHV 1979). The educational commissioners interviewed at site 32 were unable to give a clear response to the question. Since they were the designated purchasers of educational provision for community specialist practice this is a worrying trend. However, this was less marked at the other site (28) where educational commissioners were interviewed.

Looking at the concept data in Figure 7, for the various practitioner groups, each can be provisionally located on this two-dimensional outline:

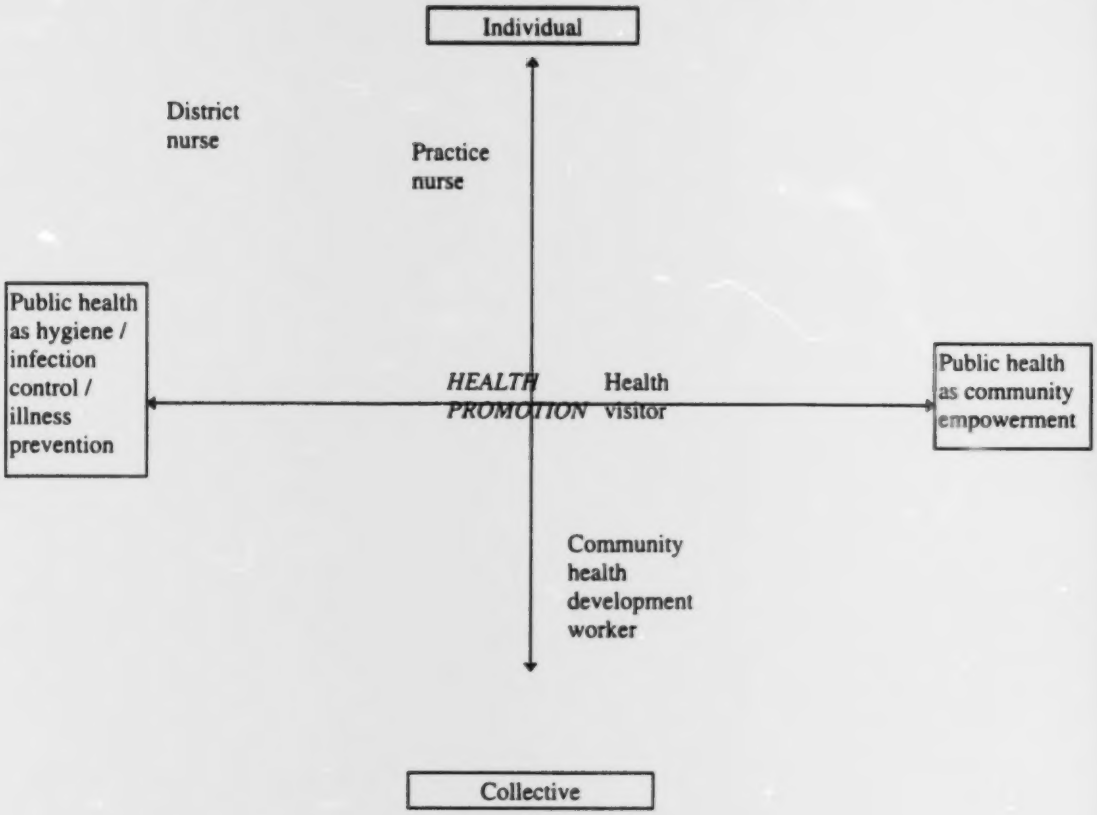

Figure 7 Location by Discipline on a Public Health Continuum

As can be seen, district nurses tended to describe public health work in terms of illness prevention with individuals. Practice nurses also largely discussed individually based work, but looked at wider aspects of health promotion. Health visitors were more likely to describe public health work in terms of seeking to identify and meet the health needs of a population or community. However, they also clearly saw themselves, and were seen by others, as experiencing a tension between the individual and the collective dimensions of their work. Those who held a community development role were seen as more explicitly able to develop a collective approach in their work, subject to a range of constraints (see below).

6.3. Perceptions of Public Health Practice

Despite the difficulties of articulating precisely what public health might mean as a concept, asked to complete a public health practice log, at least half of the practitioners interviewed appeared to have no great difficulty in describing public health activity which they were involved with (see Appendix Four). The activities described ranged widely, from domestic violence support to prevention of falls in older people. It was however clear that a considerable proportion of the examples cited were either still at the planning stage, or had met with apparently insurmountable problems in moving them forward. Many of these had related either to available time or other resourcing. The few which had got off the ground had on

the whole been subject to some evaluation but the outcomes examined had largely been 'soft'. However, it was noted that in contrast 'mainstream practice' was usually not evaluated at all.

As discussed earlier, the health benefit cycle has been suggested as a framework for evaluating methods and systems for promoting health in communities. The cycle consists of seven key steps. These were examined in relation to the examples provided:

1. Defining the health problem
   All of the examples put forward incorporated at least a brief definition of a specified health problem - for example teenage pregnancy, toddler behaviour problems.
2. Identifying potential solutions
   In each case one or more potential solutions had been identified, often, but not always involving the development of a group, or use of local networks.
3. Agreeing health priorities and outcome objectives
   Agreement of health priorities was generally implicit rather than explicit - for example in the prioritisation of resource for toddler behaviour.
4. Specifying interventions and standards required
   Where individuals described detailed planning processes it appeared that this would produce a more clearly specified intervention - as for example in the case of the domestic violence help line. Clear standards were not always specified.
5. Delivering the interventions
   Relatively few examples had reached this stage.
6. Auditing the processes of delivery against the standards specified
   As stated above, where initiatives had progressed into action, evaluation was quite common, though often relatively 'soft' - for example asking attenders their views of the initiative.
7. Re-assessing the health problem after delivery of the intervention
   Where impact had been less than anticipated, modifications to approach were proposed - for example in looking at healthy eating for young people, changing the target group slightly.

6.4. Hurdles and Levers in Learning about Public Health

Respondents were generally agreed that the major barrier to undertaking public health practice was the pressure on students and newly qualified practitioners, as well as Community Practice Teachers, to undertake mainstream / 'bread and butter' / 'hands on' practice. Even for health visiting respondents, there was felt to be a pressure to undertake what one respondent described as '*bog-standard health visiting*' and to complete more visible parts of the job - 'hands on' - rather than undertake more 'hidden' tasks such as networking with other agencies, attending meetings or organising activities. One district nurse respondent said:

"*it is time constraints and how you balance your public health role and the wider community nursing role with our activities counted by face to face contacts. That wasn't addressed on the course.*"

Mainstream practice was seen as legitimate activity whilst there was more uncertainty about 'public health' work:

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"In an ideal world we would all like to work differently I think but at the end of the day there are things that you have to get done and the routine child health surveillance is the thing that takes priority."
Alongside this were the attitudes of colleagues and managers, which were seen as having the potential to act either as a barrier or as encouragement to students and newly qualified staff. One health visitor in a focus group, asked about barriers to public health work commented:
"lack of understanding really in what the public health role is all about, I'm thinking of the Practice Manager. I'm thinking of our mother and baby support group, our Practice Manager couldn't see what having a cup of coffee was possibly doing, you know."
If managers were perceived as not valuing public health work staff appeared less likely to be pro-active and more inclined to mention management decisions as barriers in practice examples.

6.5. The Education Process

The main issue which emerged across several sites was the importance of the Community Practice Teacher's role in bridging the theory-practice gap, and helping students to see how the teaching in the academic setting made sense in the practice context. Yet where students remained locked into 'hands on' models, learning was about *"getting [them] to stand back."*
Several respondents at all sites commented on the importance of helping students to identify health needs and understand these in context. Students found it easier to recall theoretical models than practice based learning, except where this was set in a clear framework. Community Practice Teachers were seen as role models by students but were less available for practice nurses. For this group in particular, there was a tension between the diverse demands made of them by doctors (their employers) and the priorities within the curriculum.
"[GPs are] more interested in tasks and throughput of patients than quality and time". [PN 2 interjects] *"so health promotion and public health might go out the window."*

6.6. Learning about Public Health Work - An Outline Model

Figure 8 sets out a way of describing the inter-relationship between factors identified at different points in the educational process as impacting on learning about public health work. Firstly, many respondents talked about the student's prior knowledge being an influential factor in their learning. There were two strands to this - some students had prior experience of relevance - for example in community practice or in the voluntary sector. Those with *'no background'*, whose experience was predominantly in the acute sector, had therefore got more to learn. However, those who had experience were in some cases, it seemed, more able to take on board new information and process it.

The students themselves experienced time as a constraint in acquiring knowledge, skills and attitudes and in gaining experience of practice. For example the pressure to complete academic work limited students' capacity to be exposed adequately to practice settings of relevance. The curriculum was delivered substantially by lecturers who found it relatively easy to articulate their notions of public health, but harder to

describe practice. The lecturers saw their role as helping students to 'see' public health work, and enabling students to believe that they were *able* to make changes in peoples' health experience. Community Practice Teachers on the other hand perceived their role as constrained by the demands of practice, and the need to balance 'mainstream' community nursing or 'bread and butter' health visiting with public health. At one site they also lacked support. Community Practice Teachers were responsible for providing students with an appropriate framework within which to progress the development of a public health role. One of the most common frameworks used was the principles of health visiting, which respondents adapted to their own needs. Where a framework existed there appeared to be a greater security in moving the role forwards.

The practice environment in which learning occurred was noted by many respondents to offer different opportunities if it was urban or rural, affluent or poor. There was some suggestion that a relatively poor inner city area might offer better opportunities for public health work than an affluent suburb. Respondents indicated that resources - for example both material resources such as funding for study, equipment etc. - and networks of people and organisations - were required for effective learning about public health.

Transformation takes place from student to practitioner. There is then an informal period of consolidation - seeking to make sense of practice and get to grips with what is required. Similar issues arise in looking at consolidation as in the initial course time. The frameworks which have been provided continue to be used. The environment in which the new practitioner works offers opportunities for public health work which may be few or many. The resources available to develop public health work in this period also contribute to the new practitioner's development of activity in this area. The time available to the practitioner is her key resource, and respondents make clear that 'bread and butter' health visiting at this stage will often be time consuming. However, if there are active voluntary groups, or established workers with whom to collaborate, as in some of the examples given, newly qualified practitioners will begin to plan for, and sometimes undertake, public health activity.

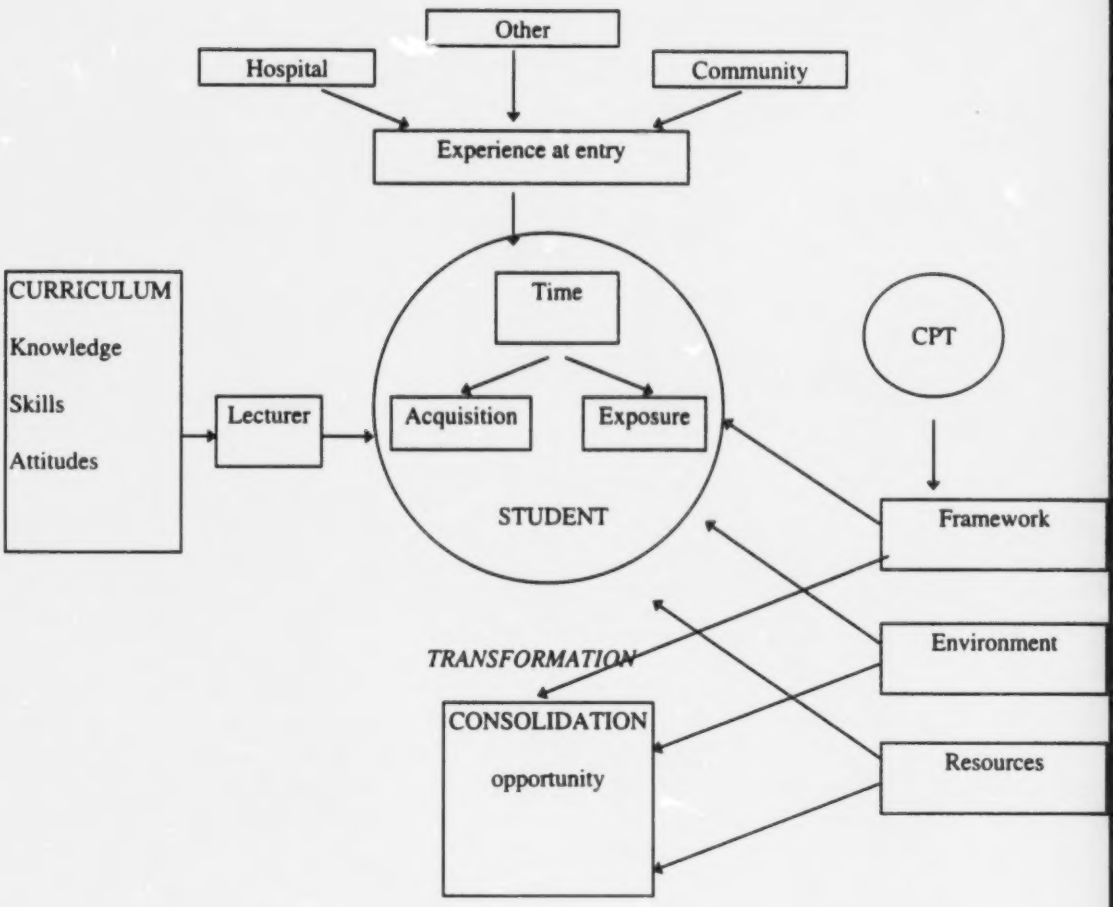

Figure 8 Learning about Public Health Work

6.7. Summary

In this chapter some of the key areas arising within the four case sites have been described. Outlining their concept of 'public health' proved to be a challenge for almost all respondents. Responses could be described on two axes. The first of these lay between individual and collective activity. The second spanned a continuum from infection control or 'hygiene' on the one hand to community empowerment on the other. Despite difficulties in explaining exactly what public health might mean as a concept, a majority of the respondents appeared to have no difficulty in completing a practice log describing public health activity which they were involved. The major barrier to undertaking public health practice was seen as the pressure to undertake mainstream, 'hands on', practice. The Community Practice Teacher was seen as having a key role in bridging the theory-practice gap, and helping students to see how University based teaching made sense in the practice context. An outline model is described which, it is suggested, offers a way of describing the inter-relationship

between factors identified at different points in the educational process as impacting on learning about public health work.

CHAPTER SEVEN

7. DISCUSSION

This chapter briefly discusses some of the key issues arising from the findings presented above. Each issue is summarised and discussed in the context of recent policy developments.

7.1 Discussion

7.1.1. Methodological Issues

In each strand of this study, methodological problems were encountered. In strands one and two, low response rates to the relatively lengthy postal questionnaires used raise questions about representativeness, and limit the level of detail which could be securely drawn from the data. The changing policy context in which the study has been carried out, and its timing, must also be noted when interpreting the results of different elements of the study. Strand three was affected by difficulties in access to selected sites, and participation rates within each site which were lower than had been hoped for. Nevertheless, in most cases the range of participants envisaged was obtained and a variety of views described. The impact of access difficulties is likely to be a move towards less 'mainstream' sites, though the sites eventually used were in a variety of settings and appeared to have many themes in common. The range of concepts which can be uncovered and the depth of analysis which can be achieved are likely to be restricted for each group (practitioners, lecturers, CPTs etc.), but within each site, exploration of issues and ideas from different perspectives provides a firmer base to work from. Exploration of common themes and areas of contrast across all four sites (in Chapter Six) highlights concepts within the data which are more secure.

7.1.2. Public Health Work - Fringe Work or Mainstream?

Probably the most important issue raised by this study is the status of public health work within community specialist nursing practice. A majority of respondents, whilst valuing the *ideal* of public health work by community specialist nurses, saw it in practice taking second place to mainstream practice and areas of work which were more concretely measurable. This theme was particularly strong for both district nurses, where the pull of immediate care tended to over-ride any more preventive work, and for practice nurses, where GPs were seen as prioritising one to one delivery of screening and chronic disease management over more population based approaches. However, it was also quite evident amongst health visitors, for whom the routines of child health surveillance acted as a similar constraint. There was also some evidence that public health work was poorly understood, and was not always valued by those such as Trust managers who could if they wished facilitate practice in this area. For practitioners in contexts where this was the case, there were indications that public health activity could be faced with insurmountable barriers.

The key questions arising are how can the status of public health work be raised, and in particular, in a context where resources are finite, how can this sort of activity, which is often time consuming and demonstrates its effects in the longer term, be supported alongside more immediate health care demands. Recent policy developments such as the Sure Start programme have begun to acknowledge the need for a longer term perspective, but have not really addressed the question of overall balance.

7.1.3. Public Health is Changing and Not Definitive

Many lecturers and Community Practice Teachers highlighted the fact that 'public health' has changed considerably since they were first introduced to it - as a concept, and in peoples perceptions of how it should be carried out. From visits to sewage works and the study of infectious disease public health has moved towards community development and health improvement plans (though infectious diseases are making a comeback in some places). Models of public health are more complex and sophisticated, integrating social and psychological perspectives alongside the biomedical, and involving the organisational and the environmental as well as the family and the community. As with many other areas of life, the changing nature of 'public health' requires those working in public health to possess a portfolio of skills which can grow and develop to meet emerging needs. For example, where today there is a need for skills in information management, in the future this may be superseded by better data management and more powerful tools in central locations. The skills required then may be in the analysis and use of an enormously expanded evidence base to identify optimum interventions, or in the development of effective collaborations with an ever growing range of other agencies and individuals. Much of this learning appears to require an appropriate framework in which to locate it. If, as has been suggested, the environment in which learning takes place and the resources available also affect the opportunities for learning about public health, these must be assessed in the light of current approaches to public health. For example, should Community Practice Teachers be debarred from teaching if they do not hold a caseload but are instead working in a community development project in a high need area?

Whilst there was evidence that curricula have been designed to take account of conceptual shifts over recent years, the current pace of change has been hard for them to match. Course Programme Directors and others will need to address how best they can enable those working in public health to obtain a portfolio of skills which can grow and develop to meet emerging needs.

7.1.4. Roles in Transition

It is not only the notion of public health which has been changing. Clearly the development of the community specialist programmes which are at the core of this study was a response to the changing needs of practice, and the changing roles which community specialists might undertake. As well as looking at specific skills, it is clear that community specialist roles remain in transition. In particular, district nurse respondents highlighted the potential which their role could have to work in different ways and with different groups, in a way which complemented other practitioners' contributions. Practice nurse respondents saw their key boundary in the development

of expanded and more specialist roles, and queried whether public health work was just 'expanded practice nursing'. Yet although there was agreement across all sites on core skills for public health work, different disciplines were located at different points in their perceptions of public health, suggesting that they might use these in different ways.

In the recent White Paper *Saving Lives - Our Healthier Nation*' (NHSE 1999) practice nurses were noted as having an important role in surgery based health promotion and disease prevention. However, though district nursing roles were valued, deficiencies in current provision (due to increased demand) were noted and the suggestion made that the interface between district nursing and practice nursing should be reviewed. Part of such a review will need to look at the complementarity of these roles with those of other community specialist nurses, and examine how far the core skills required are held and used in common.

7.1.5. Standing Back and Seeing the Landscape

In discussing how students learnt to do public health work, many respondents - lecturers and Community Practice Teachers - made reference to helping them to 'see' what was described as 'the wider picture', to transforming their perspective and helping them to see 'the landscape'. The first image which these comments conjures up is from fine art - in which a student might learn techniques of painting using simple objects to create a 'still life', then later move on to the more complex issues of perspective and distance in capturing a landscape. Equally one might consider the learner driver, unable to see anything around him whilst concentrating on moving ahead in a straight line, but surrounded by busy (and impatient) traffic. The driving instructor has to enable the learner to function at the most basic level first, then gradually become sufficiently skilled at propelling the car to begin to observe his surroundings. In the same way, both the lecturer and the Community Practice Teacher seek to systematically expand the students' horizons until they are able to identify and respond to public health needs.

In a context which has been changing, and in which traditional patterns of practice are being re-configured, it is not surprising that issues of credibility should have been raised. Community Practice Teachers questioned how far lecturers could remain credible when the pace of change, especially in the area of public health, was rapid. Lecturers were described as '*seeking and searching themselves*'. Community Practice Teachers on the other hand were seen by students as immensely credible because they were in practice - and were therefore influential as role models. Though case study data suggest that Community Practice Teachers are often more influential in shaping public health practice than lecturers, they are not always supported in this task. Further work is required to explore how this is best done, including ways of integrating learning about theory and practice.

There is evidence that after qualification too, new practitioners get caught up with developing what are still often seen as 'core' areas of practice, and without access to adequate mentoring and support may fail to see the 'landscape', quickly becoming 'still life painters'. The issue of ongoing support in developing practice, in which public health work is valued as highly as other aspects of practice, is one which must be addressed.

7.2. Summary

This chapter has addressed issues arising from the findings reported earlier. Public health work is not generally seen as 'core' work by community specialist practitioners, even health visitors. It tends to take second place to mainstream practice and areas of work which are more concretely measurable. The reader is asked how can the status of public health be raised, and in particular, where resources are finite, how can public health work be supported alongside more immediate health care demands?

The concept of public health is constantly changing. This requires those working in public health to possess skills which can grow and develop to meet needs as they emerge - flexible and transferable skills. In addition, the environment in which learning takes place and the resources available must be assessed in the light of current approaches to public health. Course Programme Directors and others will need to address how best curricula can enable practitioners to obtain a flexible portfolio of skills.

Community specialist roles remain in transition. Different disciplines have different perceptions of public health, suggesting that they might apply core skills in different ways. A review should examine how far the core skills required are held and used in common. Students learn to do public health work through learning to see 'the wider picture'. Though Community Practice Teachers appear more influential in shaping public health practice than lecturers, they are not always supported in this task. Further work is required to explore how this is best done. In addition, post-qualification support in developing practice must be addressed.

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CHAPTER EIGHT

8. CONCLUSIONS

This chapter looks back at the aims and objectives of the study, and reviews the outputs achieved.

8.1 Conclusions

Community specialist practitioners working in public health need to be proactive and imaginative, developing new ways of working to meet the community's health needs appropriately, rather than delivering traditional packages of care. A brief review of the concept of public health indicates that the health needs of any community are likely to be complex, and will require creative approaches to their solution.

The UKCC's standards for community specialist practice indicate key areas in which the newly qualified practitioner should be able to function. This study has explored how far community specialist practitioners are being prepared to develop the knowledge, skills and attitudes required to work in public health, and how far they are able to achieve public health agendas in practice.

In this project, the study team sought to explore three areas. Firstly we intended:

- ***To evaluate the effectiveness as demonstrated in practice, of the key learning outcomes of a range of specialist practitioner programmes***

In order to examine the question of effectiveness in practice, a specification for effective public health action had to be constructed. To this end, the framework offered by the health benefit cycle (SNMAC, 6.4) was used. This has been recommended by the Central Health Outcomes Unit as a framework for evaluating methods and systems for promoting health in communities. The cycle consists of seven key steps:

1. defining the health problem
2. identifying potential solutions
3. agreeing health priorities and outcome objectives
4. specifying interventions and standards required
5. delivering the interventions
6. auditing the processes of delivery against the standards specified
7. re-assessing the health problem after delivery of the intervention

As can be seen the cycle is dependent upon the definition of a particular health problem and its re-assessment after intervention, requiring measures which can distinguish appropriate levels of change.

Overall, a database of 28 practice examples was collected (Appendix Four). For each, respondents outlined what public health activity they had been involved in. Some located this in the context of an identified need, but most did not. All were asked to state what they were trying to achieve, and most could give at least outline objectives. Interventions were not generally specified in detail, and many had not yet occurred. Systematic audits were relatively rare, though some attempt at evaluation had been made in most cases where an intervention had taken place.

Looking at the effectiveness of key learning outcomes should ideally also require specification of the relevant learning objectives identified by programmes, and the ways in which these match the achievements of graduates. However, learning objectives of relevance to public health proved elusive within curriculum documentation, and were more noticeable in their absence. Chapter One sets out a commentary on the UKCC standards for community specialist practice which highlights some of the possible questions to be addressed. The qualitative evidence presented in the body of the report indicates that most newly qualified practitioners were experiencing some difficulty in achieving relevant standards in relation to public health.

Secondly, the study team sought

- ***To explore the developmental implications for the role of the specialist practitioner in the context of public health***

In order to address this aim it was necessary to examine students', course teams' and service managers' perceptions of current and future roles involving a public health remit, in order to determine agendas for service development. The perceptions of service providers were particularly important in order to determine the nature and priorities of the current work environment. However, as discussed in Chapter One, when the study was set up, the speed and quantity of change in the policy climate was not predicted, and changes of policy were emerging alongside much of the data collection period. Some of the key issues which emerged from the Strand Three data have been set out in Chapter Seven, but are recapitulated below.

Public health work tends to take second place to mainstream practice in each community specialism, and to areas of work which are more measurable. The concept of public health is constantly changing, and requires those working in public health to possess flexible and transferable skills. The learning environment and the resources available must be assessed in the light of current approaches to public health. Community specialist roles remain in transition. Different disciplines have differing views of public health, and may apply core skills in different ways. A review should examine how far the core skills required are held and used in common. Students learn to do public health work through learning to see 'the landscape'. Work is required to explore how best Community Practice Teachers can be supported in this task. Post-qualification support in developing practice must be developed and strengthened.

Thirdly the research team hoped:

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- ***To analyse the implications of developments in post-registration education for pre-registration education and practice***

The Peach Commission's recently published report on pre-registration education for nursing did not open up any debates about the nature of the experience which should be offered to students in the branch programmes. This was left as an area for future examination. The findings of this study suggest that whilst Educationalists perceive some positive features in existing pre-registration preparation as a foundation for public health work - in awareness raising in particular, twice as many felt that current patterns of preparation were variable in quality as a preparation for public health work, or inadequate. Trust and Health Authority respondents were of the view that more multi-disciplinary education should be offered in order to facilitate public health working. This study also indicates that post-registration students who have had constructive prior experience in community settings (not necessarily within their pre-registration education) are more able to seek out appropriate learning situations and to build public health activity on it. Further examination of this issue could usefully build on Carr's (1999) work exploring how pre-registration students learn about community practice. The Peach Commission did emphasise the importance of incorporating interdisciplinary learning (rather than intradisciplinary learning) within curricula, providing skills and a framework for post-registration students seeking to build up appropriate networks for collaboration. The Commission also highlighted the need to explore more effective ways of assessing practice, and integrating theory into practice. Successful approaches to these issues may be transferable to deal with issues raised in relation to the community specialist courses.

8.2 Summary

The study described in this report has examined how far programmes of education can successfully prepare community nursing specialist practitioners to carry out a public health role, and some of the factors which act as aids and hindrances in the translation of theory into public health practice once they are qualified. The study's aims have been examined. In looking at effectiveness in practice, practice examples were reviewed in relation to the health benefit cycle. They generally conformed to the early stages but were not precise. In curriculum documents, learning objectives of relevance to public health were few. A commentary has been presented in Chapter One on the UKCC standards for community specialist practice which highlights questions to be addressed in relation to public health. Evidence in the body of the report indicates that newly qualified practitioners might experience difficulty in achieving relevant standards.

Secondly, the study team looked at how current and future specialist roles might develop and considered students', course teams' and service managers' perceptions of current and future public health roles. Key issues from the Strand Three data, set out in Chapter Seven, were recapitulated.

The research team also considered the implications of potential developments in post-registration education on public health for pre-registration education and practice, and discussed the implications of the Peach Commission's recently published report. Prior experience in community settings appeared to be important in further learning about public health work. Incorporating interdisciplinary learning within curricula would

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provide a strong base for collaborative working. Successful approaches to practice based assessment and spanning the theory-practice gap may be transferable to deal with issues raised in relation to the community specialist courses.

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APPENDIX ONE

In April 1998, the UKCC published *Standards for specialist education and practice*. This followed earlier UKCC documents in defining specialist practice as 'the exercising of higher levels of judgement, discretion and decision making in clinical care'. The document sets out what is required in order for a practitioner to be recorded as a specialist practitioner on the UKCC register.

These are:

- An entry on the relevant and appropriate part or parts of the register
- Experience sufficient to consolidate pre-registration outcomes and gain deeper understanding in relevant professional practice
- Evidence that the qualification is necessary to take on higher order responsibility, and relevant and responsive to health needs
- Completion of a programme of preparation at first degree level, lasting a minimum of 32 weeks and made up of 50% theory, 50% practice.

The document lays out the outcomes which individual practitioners must achieve to be eligible for recording or registration as specialist community practitioners. All community nurses should achieve a set of 27 core outcomes, grouped under the headings 'clinical practice', 'care and programme management', 'clinical practice leadership' and 'clinical practice development'.

For example, 'clinical practice' includes the assessment of health, health related and nursing needs of patients or clients, planning, providing and evaluating specialist clinical nursing care and acting independently within a multidisciplinary context. 'Care and programme management' includes the supervision and management of clinical practice to ensure research based care, and recognition of and appropriate action on ethical and legal issues. 'Clinical practice leadership' includes not only leading and directing but also ensuring effective learning for students. 'Clinical practice development' includes initiating and leading practice development, and identifying, applying and disseminating research findings relating to specialist practice.

In addition, each of the eight types of community specialist practitioner should achieve a specific set of outcomes for that group. It is a selection of these which are examined in the main report.

APPENDIX TWO

Details of Key Colleagues/Practitioners Interviewed

Site 32

MULTIDISCIPLINARY SITE

Route Module Leaders and Lecturer(s) with a key involvement in delivering public health components of the course	**Numbers & Role** RMLHV - 1 RMLDN - 1 *CPD - (unavailable for interview)*
Focus Groups Pool of Practitioners & CPT's available to draw from: D/N=10 H/V=15 P/N=4	 Focus Group 1 year qualified PN - 2, DN - 1, HV - 4 (n=7) These numbers were achieved in 2 Focus Groups Focus Group CPT's HV (n=3) These numbers were achieved in 2 Focus Groups
Practitioner Telephone Interviews	PN's n=2 DN's =2 Practitioners 1 year qualified DN's =2 CPT's
Professional Nurse Leads in local Trust	**Numbers** 1 interviewed & 2 non-responders
Managers in local Trust	**Numbers & Role** *Telephone interview of Manager (permanent Manager on maternity leave)*
Commissioners in local Health Authorities	**Numbers & Role** Education Consortia for two counties X 2 people interviewed
Nurse Lead in Health Authority	**Numbers & Role** *Infection Control and PH Nurse, (refused interview at the last moment for political reasons)*
Director of Public Health	*Refused interview*

Site 28

HEALTH VISITING FOCUS

Details of Key Colleagues/Practitioners Interviewed

Route Module Leaders and Lecturer(s) with a key involvement in delivering public health components of the course	**Numbers & Role** CPD - 1 RML - 1
(5 refusals) Practitioners (n=35) CPTs	**Numbers in Focus Group** 4 5
5 initial messages left and contacts made	**Numbers of Telephone Interviews (& Discipline)** 2 HV's 1HV P/T CPT/ Community Development Worker 1HV/CPT
Professional Nurse Leads in local Trust	**Numbers & Role** 2 Nurse leads
Managers in local Trust	**Numbers & Role** Deputy General Manager X1 Educational Consortia Manager X1
Commissioners in local Health Authorities	**Numbers & Role** Commissioning Manager Department of Public Health X1
Nurse Lead in Health Authority	**Numbers & Role** Control of Infection Nurse X1
Director of Public Health	**Numbers & Role** Director of Public Health X1

Site 12

DISTRICT NURSING FOCUS

Details of Key Colleagues/Practitioners Interviewed

Route Module Leaders and Lecturer(s) with a key involvement in delivering public health components of the course	**Numbers & Role** RMLDN - 1 RMLDN - 1
Practitioners Total no. = 10 CPTs	**Numbers in Focus Group** n= 5 n=4
	Telephone Interviews **No consents available so unable to access names & telephone numbers**
Professional Nurse Leads in local Trust	**Numbers & Role** Professional D/N lead on secondment to Deputy Chief Executive X1 Practice Development Nurse X1 Professional Development Facilitator X1 **Telephone Interview**
Managers in local Trust	**Numbers & Role** Senior Nurse Professional Development & Nurse Lead in Child Protection to Chief Executive X1
Commissioners in local Health Authorities	**Numbers & Role** Public Health/Lead Commissioning Role X1
Nurse Lead in Health Authority	**Numbers & Role** No Nurse with wider remit in the HA, therefore omitted
Director of Public Health	**Numbers & Role** Director of Public Health **Telephone Interview**

Site 15

PRACTICE NURSING FOCUS

Details of Key Colleagues/Practitioners Interviewed

Route Module Leaders and Lecturer(s) with a key involvement in delivering public health components of the course	**Numbers & Role** RML - 1 RML - 1
Practitioners n=22 to be interviewed	**Numbers in Focus Group** N=1 N=2 N=2 (Assessors)
6 Names & Addresses in Total	**Telephone Interviews** 1 Practitioner 1 Assessor
Professional Nurse Leads in local Trust	**Numbers & Role** Assistant Director of Quality X1
Chair of LMC	*Refused telephone interview*
Commissioners in local Health Authorities N=2 interviewed together	**Numbers & Role** Commissioning Manager Practice Nurse Training (Non-nurse) X1 Commissioning Manager Practice Nurse Training (Professional Advice) (HV background) X1
Nurse Lead in Health Authority	**Numbers & Role** Nurse Lead Public Health Nursing Development Nurse (Practice Nurses)
Director of Public Health	Consultant in Public Health

APPENDIX THREE

Public Health Networks - Key Contacts in Public Health Practice

HV28/11

- Wardens of local sheltered housing: 'I am working with them to identify health promotion needs in their clients so that I can then develop appropriate groups'
- Health visitor assistant: 'She identifies individual health needs'
- GPs
- Practice nurses
- Health promotion unit
- Other health visitors
- Social workers
- Local social services day nursery
- Housing officers

HV28/22

- Midwife: 'Regular liaison re new mothers or pregnant mothers who are being transferred to care of health visitor. Also joint antenatal classes'.
- Other health visitor: 'Work together, share office, attached to same group of GP's. Look at health needs of community together. Try to address health needs.'
- GPs: 'I try to work with GPs but not really interested'
- School teacher
- Members of the community I work in
- Social worker
- Psychologist
- Practice nurse
- School nurse
- People in voluntary agencies eg Meet a Mum Association: 'New MAMA group, providing social support for new mothers and mothers with postnatal illness. At the moment working together has only meant referring mothers to MAMA and meeting MAMA volunteers to learn about our roles.'
- Nursery staff

HV 28/33

- Other health visitor: 'Working together to develop a 1 year clinic, to address issues that may present between 1-2 years of age eg behavioural issues. Also behavioural clinic run weekly - drop-in arrangement'
- Midwives: 'To provide a series of classes for women in the antenatal period'
- Youth workers: 'Part of a working party to set up a domestic violence advice line'
- GPs and district nurses: 'Weekly meetings to discuss client caseloads and exchange information. Also primary health care team meetings 3 monthly - to focus on particular areas of public health'
- Social services
- Nursery

- Voluntary agencies and charities 'eg X Drug Project'
- Speech and Language therapists
- Audiologist
- Orthoptist
- Police
- Housing department

HV 28/44

- Cardiac Liaison Nurse: 'liaising closely to support young mums with sick child at home. Liaise by phone usually weekly or meet at hospital'
- GP: 'Regular weekly meeting with GP - listen to each other. Usually available between times if required'
- Social services: 'Telephone calls and letters'
- Other health visitors: 'work as a team, support each other, discuss familes of concern, aware of problems - maintain a sense of humour.
- Admin and clerical staff at GP surgery
- School nurse
- Practice nurse
- District nurse
- Community paediatric services
- School
- Local chemist
- Voluntary groups

NQHV 28/55

- Midwives
- Community Psychiatric Nurse
- District nurses
- Practice nurse
- GPs
- Specialist nurse for enuresis
- PAMs

NQHV 28/66

- Social workers
- Health visitor colleagues
- School nurses
- Voluntary organisation
- Housing department
- Playgroup leaders
- Health promotion specialist

NQHV 28/12

- Social worker
- Health visitor colleague
- Health promotion specialist
- School nurse

- Play group leaders
- Toddler group leaders
- Voluntary organisations
- Housing staff

NQHV 28/10

- Midwife
- Community psychiatric nurses
- GPs
- District nurses
- Practice nurses
- Specialists eg enuresis
- Speech and language therapists
- Audiologists

APPENDIX FOUR

Examples of Public Health Practice in Health Visiting

Code:
HVCPT28/1

What happened:
Introduction of safety loan scheme within the local area

What the practitioner was trying to achieve:
To improve home safety in vulnerable and needy families. Also to increase awareness of accidents and preventive methods available with all clients

Has anything changed?
Yes - increased uptake of safety equipment, decreased accidents reported in A&E

Factors which helped or hindered:
Backing by voluntary agency helped to start scheme. Collection of deposit difficult therefore stopped.

Code:
HVCPT28/1

What happened:
To establish a teenage child health clinic and support group

What the practitioner was trying to achieve:
To offer support, advice and education in an acceptable situation to the client group

Has anything changed?
The client group has welcomed the opportunity to be seen in their own group and to discuss issues relevant to them.

Factors which helped or hindered:
Time constraints of caseload - delay in setting up group - lack of appropriate venue and money

Other comments
Difficult to involve some teenagers who could do with the support but reluctant or unable to attend due to social / domestic problems

Code:
HVCPT28/2

What happened:
[Planning] to prevent behaviour problems

What the practitioner was trying to achieve:
To achieve parental understanding and knowledge of children, looking at needs of children and parents (mostly single young mothers), encourage positive play, managing behaviour of child, enjoying being a mum. Target group - child aged 12-15 months

Has anything changed?
N/A

Factors which helped or hindered:
Facilities are available, with good support from GPs, who also have money if needed

Other comments
Would hope group would achieve aims and also reduce isolation of these young mums

Code:
HVCPT28/2

What happened:
'What's for tea mum' - healthy eating on a budget

What the practitioner was trying to achieve:
Promoting balanced diets

Has anything changed?
A few parents have tried recipes available. Some gained new ideas.

Factors which helped or hindered:

Other comments
Target more specifically. Try something similar in schools, especially the 'comp'.

Code:
HVCPT28/3

What happened:
Working party group meetings were arranged to discuss the project, including health visitors and other members of the multidisciplinary team (eg youth club, women's refuge workers etc)

What the practitioner was trying to achieve:
Domestic Violence Phone Advice Line - to promote advice and support to victims of domestic violence

Has anything changed?
Progress has been made through meetings of the working parties, but more organisation is still required. Objectives and aims were identified at the start - clear goals.

Factors which helped or hindered:
Finances - working to a budget
Ability - a need for some staff training was identified
Time to attend working parties

Other comments
It has been recognised that once this is in place, evaluation should be done at intervals to review the project.

Code:
HV28/3

What happened:
Held an open evening at the health centre with the aim of introducing the service to patients (women, identified age group)

What the practitioner was trying to achieve:
Setting up a menopause clinic within the health centre, ultimately to be managed by the practice nurses

Has anything changed?
Good introduction

Factors which helped or hindered:
Time

Code:
HV28/4

What happened:
I am working part-time as a health visitor for the elderly, and I and a number of colleagues are keen to introduce exercise classes for elderly to promote health and specifically promote balance and prevent falls.

What the practitioner was trying to achieve:

Has anything changed?

Factors which helped or hindered:
Need training in specific exercises for balance.

Other comments
In the past I have worked in the voluntary sector, where part of my remit was fund-raising. Therefore, once a need was identified, funds were therefore found to move the project on - as this is not seen as normal practice in health visiting (nor are we trained) - fund-raising can be a problem - and this can prevent or delay projects. Also, don't think we always use health profiles well - they tend to be stuck on shelves - and not used creatively - really due to lack of time.

Code:
HV28/4

What happened:
As a health visitor, I and the health visiting team have worked with social workers and staff from a local social services nursery to plan and run positive parenting courses.

What the practitioner was trying to achieve:
To work with parents to help them:
1. Develop parenting skills
2. Prevent behaviour problems for children / develop coping strategies
3. Promote supportive group and therefore reduce isolation

Has anything changed?
Short term results seemed good - but no follow-up long term.

Factors which helped or hindered:
I felt that we did not have adequate funds, resources or backing to advertise / market the course well. Nor did we use the local media to help promote the course, therefore numbers were low.

Other comments
Often lack info. (up to date) on relevant voluntary sector groups in local community

Code:
HV28/5

What happened:
What we hope to start / happen - increased support for breast-feeding mothers through increasing work hours of health visitor colleague who is qualified national childbirth trust breast feeding counsellor, to enable her to be available for mothers experiencing breast feeding problems.

What the practitioner was trying to achieve:
Aim is to offer service to mothers outside current health visitor's caseload, who could self refer or be referred by other health visitors in the Z area.

Has anything changed?
At proposal stage

Factors which helped or hindered:
Senior management not being sure whether money to pay for extra health visitor hours. Cannot get off the ground without funding for extra health visitor hours.

Other comments
Money often needed for initiatives and if not available initiative cannot get past idea stage. Extra health visitor time often needed and not available.

Code:
HV28/6

What happened:
I gave a seminar / talk to 50 pre-retirement group at a major local employer

What the practitioner was trying to achieve:
I was trying to make more people more active more often

Has anything changed?
I have had reports of only a few long term successes but I had more than three quarters report in the short term a feeling of change in planning.

Factors which helped or hindered:
Not knowing anyone's background health profile, attitudes might have hindered. What helped was my experience of nursing.

Other comments

Whilst large group interventions may or may not change behaviour, there are other issues eg seeing health professional in the workplace and not disease focused. I feel that the use of humour helps the impact of the message.

Code:
HV28/6

What happened:
I have many above national percentage under 16 years mothers at present.

What the practitioner was trying to achieve:
I have interviewed each one individually to ascertain why failed contraception - didn't think it would happen to them.

Has anything changed?
My attitude has changed - ie I thought it was access - it wasn't.

Factors which helped or hindered:
The girls' honesty has helped me. Their attitude towards coming to groups hinders the process of further work.

Other comments
Listening to the individual was really useful and I am considering public health teaching at the time of school leaver immunisation programme - a time when it may be possible to discuss health issues, one of which could be sexual health.

Code:
HV28/7

What happened:
Role as health promotion co-ordinator for the area - hours withdrawn to provide liaison HV to A&E and paeds.

What the practitioner was trying to achieve:
Liaison role recommended under Children Act.

Has anything changed?
No co-ordination of health promotion. Individuals still trying to provide and balancing with busy caseloads. One to one health promotion still taking place.

Factors which helped or hindered:
Logistics. Health promotion unit based at Z (?40 miles). Huge re-organisation at health promotion unit and turnover of staff.

Other comments

Code:
HV28/8

What happened:
Disabled person, breeding dogs and birds, living alone, small income and benefits for care being disseminated to wrong situations.

What the practitioner was trying to achieve:
Guidelines on more control to prevent infestation and unhygienic environment so illness and allergy content did not increase.

Has anything changed?
Rights and limitations of controlling bodies to allow guidance and authorisation to prevent continual abuse of system.

Factors which helped or hindered:
Highlighting the health issues around the situation, but not having it acknowledged by family or profesionals, before alternative may cause further issues.

Other comments

Code: DN12A.

What Happened;

Patient discharged home prematurely.

What was the practitioner trying to achieve:

District nursing intervention to keep patient at home i.e. with nursing care, management of illness, social support, health promotion.

Factors which helped or hindered:

situation exacerbated by Christmas period; poor availability of support services. Large proportion of nursing time spent with this patient to the possible detriment of others.

Has anything changed:

No comments about changing the situation for future patients.

Code: DN12B

What Happened;

Four children diagnosed with meningitis C, from one school.

What was the practitioner trying to achieve:

Primary preventative measures for other children and their families. Support and information for community.

Factors which helped or hindered:

Government policy and restrictions of spending were perceived to impede the availability of primary prevention for all. This led to anger and distress amongst parents.

Has anything changed:

There were impending changes at the time of writing. Although there currently continues to be problems with provision of the vaccine.

Code: DN12B (cont).

What Happened;

Elderly, unsupported person fell and sustained fractured arm.

What was the practitioner trying to achieve:

Enable to stay at home, supported by rapid response, multi-disciplinary approach. Whilst social services were slow to respond, the Rapid Response Team has filled the 'gap'

Factors which helped or hindered:

'Winter bed money' funding to provide assessment of needs and support

Has anything changed:

The provision of this service has facilitated good communication and collaborative networks.

Code: DN12D

What Happened;

Practice Health Needs Assessment identified falls in the elderly as area to be targeted.

What was the practitioner trying to achieve:

Primary and tertiary preventative measures to be implemented to support patients after falls and reduce incidence.

Factors which helped or hindered:

Assessment of causes were relatively simple, e.g. improved lighting, ill-fitting footwear remedied, although social services occupational therapy assessment had six month waiting-list, and subsequent further wait for equipment.

Has anything changed:

Whilst the problems of delivering support to those people who had had accidents was still delayed, the team focus on preventing accidents with simple interventions was perceived to have reduced the incidence.

Code: DN12E

What Happened;

A male district nurse tried to set up a well-man's clinic

What was the practitioner trying to achieve:

Address the perceived imbalance between men and women's access to health promotion services. This included looking at reasons why men weren't apparently accessing preventative services.

Factors which helped or hindered:

Problems arose from inter-professional rivalry between district nurse and the practice nurse, who perceived health promotion as her domain. In addition the overall uptake of the service was poor.

Has anything changed:

Raised awareness for the individual that the service may be more effective if developed in a more accessible environment, i.e. pub or gym. Knowledge that good ideas may not always be acceptable to other members of the primary health care team and that innovative ideas cannot work without inter-disciplinary collaboration and team work.

Code: CPTDN1

What Happened;

Some years ago a project was set up in a deprived part of the city to encourage people to reflect on their lifestyles in relation to their health needs.

What was the practitioner trying to achieve:

Empowering approach to identify clients own health needs.

Factors which helped or hindered:

Other (unspecified) colleagues felt it was not an appropriate use of the district nurse's time.

Has anything changed:

A belief that positive changes have been achieved because people have contributed to the things that have effected them (although no specific comments are made on what these may be).

Code: CPTDN2

What Happened;

A project set up in the area involving football teams in the Saturday league.

What was the practitioner trying to achieve:

Targeting health promotion with young men 18-30 years who do not usually access health care or advice.

Factors which helped or hindered:

This was facilitated by seeking out the men at their training nights, in order that they didn't have to attend clinics during paid employment time. This was also valued by the men who received health assessments as one had recently had a fatal heart attack whilst playing!

Has anything changed:

Not sure yet, effectiveness planned to be evaluated after this was written.

Code: CPTDN2 (cont)

What Happened;

Contributed to a women's health programme in a very deprived area of the city.

What was the practitioner trying to achieve:

Promote healthy lifestyles, increase clients knowledge and *'hopefully'* change behaviour.

Factors which helped or hindered:

The sessions were often poorly attended (4 people for a two hour session). *'Women arrived smoking, drinking coke, and eating chocolate to a healthy eating session'.* There were concerns that some of the participants had repeated the programme *'3 times over 2 year-why?'*

Has anything changed:

The observation that people are repeating the programme may suggest that it was being used to access social support (which may have been beneficial in itself). However, there was no evidence that this proposition was developed further.

Code: CPTDN3

What Happened;

Identification of high incidence of obese, hypertensive clients, attending the Treatment Room with a variety of health needs and on large numbers of medications.

What was the practitioner trying to achieve:

To identify if any of the clients could reduce their hypertension by lifestyle changes, thus producing ensuing medication and treatment reductions.

Factors which helped or hindered:

This was an individual enterprise that was unsupported by management and thus imposed time constraints upon the practitioner. Considerable amounts of commitment were required by the district nurse to identify the clients and then to persuade them to attend the sessions.

Has anything changed:

This development has been sustained by the Practice who now fund the district nurse's time. Two groups of ten clients attend the sessions, although there is no mention of objective measures to evaluate medication reduction etc.

Code: CPTDN4

What Happened;

Decided to raise awareness of diabetes. During Treatment Room sessions, patients were offered urinalysis and given information about healthy eating. Practice nurse agreed to see patients identified with potential diabetes.

What was the practitioner trying to achieve:

To raise awareness of diabetes and the links with healthy eating and working in partnership with the practice nurses.

Factors which helped or hindered:

The practice manager hindered the work, suggesting that it was the role of the practice nurse, not the district nurse. It also represented a considerable workload for the district nurse team.

Has anything changed:

It was perceived to have facilitated team-work between the practice nurse and the district nurse's.

Code: PN1.

What Happened;

There was a perception that there was insufficient time in the practice nurse's well-woman clinic to fully assess the needs of menopausal women.

What was the practitioner trying to achieve:

To further develop the service for clients, from a preventative perspective (e.g. smoking cessation - described as *'public health needs'*). Also to develop the professional role of the practice nurse.

Factors which helped or hindered:

The input / networking with other health professionals helped.

Has anything changed:

This initiative was *'audited'*, by means of questionnaire to patients. The findings were presented to GP's and a separate service was subsequently developed. This practitioner also believes that they have pushed the boundaries of practice nursing as a profession forward by developing the role further.

Code: PN2

What Happened;

PHCT decided to address teenage health needs. However one GP was unhappy with the notion of inviting patients to the surgery for this purpose (no statement of why this was). The practice nurse decided therefore, to access this group by visiting the local youth club, at their invitation.

What was the practitioner trying to achieve:

To offer teenage girls support to stop smoking, if they wanted to.

Factors which helped or hindered:

Team approach to intervention (health visitors, school nurse, practice nurses and youth workers). Time was a major issue. In particular for the practice nurses who provided this service in their own time (unlike the other professionals whose time was supported by their employers, the practice nurses time was not. This perfectly illustrates the differences in terms and conditions of employment for this particular group of community nurses).

Has anything changed:

Four girls stopped smoking.

Code: PN3

What Happened;

A Health Fair was organised by a practice nurse in an area of high deprivation.

What was the practitioner trying to achieve:

To broaden the publics perception of the surgery as a resource for health rather than simply a place to visit for illness.

Factors which helped or hindered

The initiative was hindered by a lack of enthusiasm for the project by the GP partners, whilst various nursing disciplines, other agencies (voluntary and statutory) felt very positive.

Has anything changed:

'No' The practice nurses believed that had greater support been available from the GP's, *'other excellent projects could have grown from it'.*

Code: PNAssessor1

What Happened;

A young mother, whilst discussing her child with asthma, opened up to the practice nurse in relation to her wider, social situation.

What was the practitioner trying to achieve:

To offer support to the client, using a family-centred approach.

Factors which helped or hindered:

Knowledge of asthma management, knowledge of networks to provide social support for family.

Has anything changed:

Improved relationship with mother.

Code: PNAssessor2

What Happened;

Collaborative *'exercise event'* organised, including a full day of activities, but also to include other health issues. Developed with other health professionals, patients, youth worker, sports centre manager and community police constable.

What was the practitioner trying to achieve:

To increase awareness of the benefits of exercise in the maintenance of good health or to improve poor health.

Factors which helped or hindered:

The positive enthusiasm and willingness of individual members of the team and steering group to get on board and take a lead.

The negative included the reluctance of some others to participate.

Also the project involved huge amounts of work for the co-ordinator (the practice nurse). This was undertaken voluntarily, which struck the practice nurse as *'odd as*

the initiative was a public health project, of which you would expect the provision of funding'.

Has anything changed:

The event had not taken place at the time of writing but was already yielding positive results from working with different disciplines and organisations, which was improving communication and co-operation.

APPENDIX FIVE

Standards outlined in Feasibility Study Of The Case For National Standards For Specialist Practice In Public Health

1. **Understanding health and disease; measuring health status**

- To understand human health and disease and to determine and understand the major biological, political, social, environmental and lifestyle factors influencing health status and the burden of ill health.
- To examine known risk factors and the evidence of risk.
- To develop the techniques of health impact assessment to make it more reliable, useful and routine.

2. **Disease surveillance and control**

- To monitor the instance of disease, both communicable and non-communicable; maintain appropriate records and report findings effectively.
- To take effective action to prevent and control the spread of communicable diseases.
- To address and control the risks to the public health posed by non-communicable disease and lifestyle choices.
- To monitor and control the impact on health of environmental hazards.

3. **Promoting health and well-being**[2]

- To understand the key determinants of behaviour change and how these characteristics vary across populations.
- To identify the essential characteristics of negotiating strategies and which work best on different groups and in different circumstances to improve the population's health.
- To understand community development and partnership approaches to addressing the social and economic factors that underpin poor health.
- To develop measures of effectiveness for public health initiatives that aim to promote health and wellbeing.

4. **Evaluating and improving the effectiveness and efficiency of health care**

- To understand and apply measures of effectiveness and efficiency in making (or informing) management choice and developing health services.
- To use resources efficiently to maximise health benefit.
- To develop the methods by which the actual contribution of improved population health to economic and social development can be reliably assessed.

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[2] It would be inappropriate to seek to detail the way health promotion should be practised since it is already governed by a comprehensive set of standards. However, standards for public health would be incomplete were they not to set out the importance of health promotion and to recognise and be informed by the existing guidelines.

5. **Evidence based decisions, information management and research**

- To understand and interpret different sources of information and to be able to evaluate and use them effectively whether they are statistical, epidemiological or qualitative.
- To seek out evidence and research before taking decisions and to take decisions in line with the best evidence available.
- To maintain an up to date knowledge of relevant research and research methods and to manage information sources effectively.

6. **Advocacy**

- To determine the policy sectors which can influence the key determinants of health and identify how they rank in terms of public health consequence and their effects on other aspects of public life.
- To identify the key 'common cause' factors for moving these policy sectors nationally and locally; to be aware of the means of exerting influence; and to understand where the areas of resistance lie.
- To understand how to track the policy change process to measure the real factors which can contribute to, or block progress towards, greater health gain.

7. **Communication and co-ordination**

- To set out detailed local measures of outcome and quality and disseminate them, being explicit about what specialist public health has to offer.
- To provide clear messages that are accessible to client groups and collaborators alike and allow them to participate in debate.
- To co-ordinate efforts effectively to ensure links across agencies and to avoid duplication.

8. **Inter-sectoral and collaborative working**

- To recognise and appreciate the contribution of the diverse disciplines, groups and professions that contribute to the health of the public and to actively encourage their participation, facilitating links across sectors and encouraging full participation.
- To be expert in determining how 'public health' should position itself between the multiple sectors with public health influence and to actively seek involvement with them in pursuit of health gain.
- To ensure that public health policy is informed and directed by the full range of specialists, disciplines and skills involved and that decision making is based on consultation and the best evidence available.

9. **Management and leadership**

- To provide effective strategic leadership for public health initiatives at all levels of policy making.

- To marshal the relevant information, research and knowledge of best practice to ensure that change is planned, implemented and evaluated efficiently.
- To run a cost-effective and well-led service that maximises the public's and its own staff's health.
- To put in place mechanisms for appropriate and ongoing multidisciplinary, professional development and acknowledge the contribution it makes to specialist public health practice.

10. Modelling the future of public health

- To develop the capacity to use public health knowledge and theory to forecast future public health outcomes in a rapidly changing world.
- To apply management tools that facilitate the use of forecasting in planning and decision making and ensure the review, assessment and refinement of such forecasts.

These outline 'standards' draw on all the skills and disciplines that are currently acknowledged as contributing to public health. They clearly demand competence in epidemiology; disease prevention and health promotion; health information; biology; clinical medicine; immunology; statistical methods; medical sociology and health psychology; social policy and health economics; and the organisation and management of health care for example. Many of these currently form the core of the syllabus for the Diploma Examination for Membership of the Faculty of Public Health Medicine, which is now under review. They are however grouped to reflect the complexity of specialist public health and the way that distinct skills must be meshed together in order to deliver the component parts of specialist practice.

APPENDIX SIX

Evaluation of the Developing Specialist Practitioner Role in the Context of Public Health

Case Study Sampling Frame

Discipline Route Module Leader (Health Visiting)/DN/GP/SN
Site Number _____

Priorities for public health:-
Mention any of the top five for this discipline

Strengths:-
Course material/content
Practice links

Other
Top five

Weaknesses:-
Centred on education setting eg resources

Centred outside educational setting eg fundholders. CPT's, students

Key public health functions for this discipline:-
Mention any of the top five

Mention an unusual/well argued function

Teachers in educational setting:-
Range of types/disciplines mentioned

Obstacles in practice setting:-
Focus of work eg medical, traditional, individual

Attitudes
Organisational/structural
Resources
Other

Other comments:-
eg do you feel it is exciting? awful? - gut feelings and/or evidence?

APPENDIX SEVEN

Original Sampling Strategy for Site 32

Educational Institution

- Programme director x 1(I)
- RMLs x 4 (I)
- Other lecturers x 2(I)
- Students (FG)
- CPTs (FG)

Selection of Students

- Recommendations from lecturing staff
- Self selection
- Random selection from above
- Ideally we would want to recruit students from one trust if possible

Selection of CPTs

- Consent following student allocation (we will select the student first, and then link to their CPTs)

Selection of Trust Personnel

- If possible single Trust per case study
- Director of Nursing x 1(I) to gain a strategic view of PH within the Trust.
- Locality Co-ordinators x 2 (I) to gain a more operational view of PH
- Director of Primary Care x 1(I)
- Practitioners x 12 (I) - HV,(3) DN,(3) GP,(3) SN(3)

Selection of HA's Personnel

- Director of Public Health x 1
- Nurse Advisor x 1

Selection of PHCT's Personnel

- GPs x 12 (I)
- Community Nurses x12 (I)
- Other agencies x 12 (I)

Secondary Data Collection

- Public health logs and key contacts

- Course curriculum from educational establishment
- Trust/Health Authority reports and strategies

APPENDIX EIGHT

ID

Exploring the Public Health Role of Specialist Practitioners: Community Health Care Nursing

Course/Programme Directors Questionnaire

The English National Board have funded research at the University of Newcastle in association with the University of Northumbria to explore the public health role of community health nurses specifically practice nurses, district nurses and health visitors. Defining public health is a challenge to us all and the ENB recognise that all educational institutions are in the initial implementation stage on the New Specialist programmes and so are seeking your early responses to this new development, in order to faciliatate appropriate changes in current policy and practice.

This questionnaire represents Strand One of a national project and has been sent to all course directors across England in order to establish the views and perceptions of this key group.

It is important for us to gain your views and perceptions in order to provide a national perspective on how the public health role is developing within community nursing practice. Your contribution at this stage will provide an essential foundation for further in depth exploration in Strand Three, whilst contributing to a unique body of developing knowledge about the public health remit for community nurses in meeting today's health needs.

In order to meet the research aims and to ensure data are meaningful, we have utilised a qualitative format. Although this may require more of your time to complete, we hope it will provide results that can be disseminated back into both education and practice to facilitate the continued development of the public health role.

The responses given in this questionnaire will remain confidential to the research team but are not anonymous due to the potential need for follow up. The ENB are not informed at any stage of the location of the research sites.

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ID

It is clearly important for us to appreciate your views on the role of public health and how it is developing. This role continues to develop and there is no 'right' answer to any of the following questions, instead we are seeking to understand the factors which you see as influencing public health nursing practice whilst exploring the contribution that the educational process can make to practice development.

SECTION ONE

1. Please comment on, what you see as, the major priorities for public health in the coming decade.

2. Please comment on your Specialist Practitioner Programme as a foundation for meeting the public health needs of today?

3. Please state what you consider to be your programme's current:

Strengths:

-
-
-

Further comments if you have any:

.....
.....
.....
.....

Weaknesses:

-
-
-

Further comments, if appropriate:

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4. Can you identify any national or international developments/directives which have **influenced** the way your courses prepare students for a public health role?

Please state what these influences have been:

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Further comments, if desired:

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5. As we are looking at the public health role of health visitors, general practice and district nurses, please indicate what you perceive to be the key specific functions which highlight differences within the **public health** role for each of the specialist programmes offered.

Public Health Nursing - Health Visiting

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Further comments, if desired:

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General Practice Nursing

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Further comments, if desired:

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Community Nursing in the Home - District Nursing

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Further comments, if desired:

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6. Please describe the key functions of the **public health** role which you see **ALL** specialist community nursing practitioners performing, once qualified?

This question seeks to obtain your views and perceptions on the broader concept of what constitutes a public health role across the <u>three</u> community specialist programmes (general practice nursing and district nursing, health visiting).

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Further comments, if desired:

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7. In relation to achieving a public health role, what, if any, are the obstacles and opportunities arising in the **work environment** which, you feel, may impact on Specialist Community Nursing Practitioners successful implementation of this role?

Please specify according to each professional programme which you cover.

General Practice Nursing

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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Community Nursing in the Home - District Nursing

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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Public Health Nursing - Health Visiting

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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7a. Please state the title and professional experience of whoever is/will be providing teaching around the **public health** role for students when they are in their educational institution?

Please specify according to each professional group.

Public Health Nursing - Health Visiting

Title:	Professional Experience:
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General Practice Nursing

Title:	Professional Experience:
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Community Nursing in the Home - District Nursing

Title:	Professional Experience:
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7b. Please state the title and professional experience of whoever is/will be providing teaching around the **public health** role for students when they are <u>in</u> the practice setting?

Please specify according to each professional group.

Public Health Nursing - Health Visiting

Title:	Professional Experience:
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General Practice Nursing

Title:	Professional Experience:
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Community Nursing in the Home - District Nursing

Title:	Professional Experience:
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7c. Are you aware of any other issues occurring in the work environment which are raised by the students, which need to be addressed in order to enable them to fulfil their public health remit?

Please specify according to each professional group.

Public Health Nursing - Health Visiting

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General Practice Nursing

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Community Nursing Specialist in the Home - District Nursing

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SECTION TWO

Future Developments

It would be useful for us to gain an understanding of your vision around the future development of the public health nursing role. Please answer the following questions which seek to explore your views on such developments and how the educational process might influence this.

8. Please describe how you see **post registration education** for a public health role developing in the next five years?

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9. Please describe any current **developments or innovations** within your community nursing specialist practitioner programme which you consider particularly useful in preparing the practitioners for their public health role?

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10. What are your views about current **pre-registration education** (Project 2000) as a **foundation** for preparing community nurses to work in a public health role?

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If you would like to be considered for inclusion in the sampling matrix for Strand Three, please complete the section below. This will help us to assess the type and scale of the New Specialist Community Practitioner Education you offer. This information will remain confidential to the research team.

SECTION THREE

11. What was the date of validation for your specialist Practitioner Programme?

DATE of validation.....

12. In Strand Three we need to access students who will have qualified by October 1997 in order to access their experience six months after qualification, in the case studies which begin in April 1998.

    Please confirm which courses you offer which would have produced qualifiers by October 1997 from either part-time or full-time courses, please tick the appropriate boxes.

General Practice Nursing ●

Public Health Nursing - Health Visiting ●

Community Nursing in the Home - District Nursing ●

Others, please specify:

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.....

13. For each programme you offer, please fill in the relevant boxes which correspond to the number of students completing the course in the following years.

		1996/97	**Projected 1997/98**
General Practice Nursing	Less than 10 students	●	●
	More than 10 students	●	●

Public Health Nursing - (HV)	Less than 10 students	●	●
	More than 10 students	●	●
Community Nursing (DN)	Less than 10 students	●	●
	More than 10 students	●	●

14. Please indicate any areas where you have experienced significant change in offering the new Specialist Practitioner Community Nursing Education in the past three years, please tick the appropriate boxes and add further comments.

Staffing of course/s ●

Please comment:

.....
.....

Curriculum content ●

Please comment:

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Trusts/Fundholding Practices ●

Please comment:

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.....

Consortia ●

Please comment:

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Other comments:

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Please feel free to make any additional comments in the space provided below:

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Thank you very much for your time

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Exploring the Public Health Role of Specialist Practitioners: Community Health Care Nursing

Trust/Health Authority Questionnaire

The English National Board have funded research at the University of Newcastle in association with the University of Northumbria to explore the public health role of community nursing practitioners.

Defining public health is a challenge to us all. We recognise that educational institutions are in the initial implementation stage on the New Specialist Programmes and so are seeking your early responses to this development (UKCC 1994). Questionnaires have already been sent out to all Educational Course Directors and Route Leaders responsible for the specialist programmes in England. This questionnaire to Trust Nursing Directors and Health Authority Nurse Advisors will contribute to a National perspective on how the public health role is developing within community nursing practice. Your contribution at this stage will provide an essential foundation for further in depth exploration, whilst contributing to a unique body of developing knowledge about the public health remit for community nurses in meeting today's health needs. This questionnaire aims to gain a strategic and operational overview. Some of the questions therefore may need to be completed with the help of operational managers with whom you work. Practitioners themselves will be consulted at a later stage.

In order to meet the research aims and to ensure data are meaningful, we have utilised a qualitative format. Although this may require more of your time to complete, we hope it will provide results that can be disseminated back into both education and practice to facilitate the continued development of the public health role.

The responses given in this questionnaire will remain confidential to the research team but are not anonymous due to the potential need for follow up. The English National Board are not informed at any stage of the location of the research sites.

Please find enclosed a summary of the project for your information.

Public health is not easy to define or describe overlapping as it does with primary health care and health promotion. However, the following definitions may help you when completing this questionnaire.

In general, public health is:

'a collective or population view of the health needs and health care rather than one which focuses on individuals.'

(NHSE 1997)

Public health nursing shares the following characteristics:

- *monitoring the health of populations and communities and identifying health needs.*
- *undertaking public health action with local communities.*
- *inter-agency work to improve local population health eg. accident prevention.*
- *participation in communicable disease control eg. HIV, TB.*

(NHSE 1997, SNMAC 1995)

ID

SECTION ONE

About your Organisation

1. What type of organisation do you work in?

Please tick:

Health Authority ●

N.B. If you work in a Health Authority, for the purpose of this questionnaire please consider your **organisation** as encompassing the Health Authority and the other organisations in your geographical catchment area.

Trust ●

1a. If you work within a **Trust**, please tick the box which most accurately describes the organisation you work in.

If you work within a **Health Authority** please go on to the next question.

Community ●

Community & Mental Health ●

Community & Acute ●

Other, please specify .....

1b. Describe the population served by your **Trust/Health Authority**.

Please tick below:

Rural ●

Urban ●

Mixed ●

SECTION TWO

Public Health and Community Nursing Practice in your Organisation

2. Please comment on, what you see as the major priorities for public health in the coming decade.

Nationally determined (Please state the names of any appropriate documents from which you are working)

-
-
-

Locally determined

-
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3. Please describe the **key functions** of the **public health** role which you see **ALL** community nursing practitioners performing, once qualified.

This question seeks to obtain your views and perceptions on the broader concept of what constitutes a public health role within community nursing.

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Further comments, if desired:

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4. So we can look more specifically at the public health role of general practice nurses, district nurses, health visiting and school nurses please indicate what you perceive to be the key **specific functions** which highlight differences within their **public health** roles.

General Practice Nursing

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Further comments, if desired:

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District Nursing - Community Nursing in the Home -

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Further comments, if desired:

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Health Visiting (Public Health Nursing)

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Further comments, if desired:

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School Nurses

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Further comments, if desired:

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In relation to achieving a **public health role**, what, if any, are the **obstacles and opportunities** arising in the **work environment** which, you feel, may impact on community nursing practitioners successful implementation of this role?

Please specify according to each professional group.

5a. **General Practice Nursing**

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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5b. **District Nursing (Community Nursing in the Home)**

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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5c. **Health Visiting (Public Health Nursing)**

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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5d. **School Nursing**

Obstacles in the work environment:

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Further comments, if you have any:

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Opportunities in the work environment:

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Further comments, if you have any:

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SECTION THREE

Wider Issues in Contracting and Delivering Community Nursing Services

6. Nurses and health visitors have an important contribution to make to public health work or contracting intentions if in a Health Authority. Please describe how these nurses are involved in this work within your organisation and how you enable them to contribute to the delivery of public health practice. We would like you to detail the contribution made towards health needs assessment, strategic planning or contracting. Please feel free to add any additional areas you see as important in their contribution or note an absence of their involvement if you feel this to be more accurate.

Contributions made within:

- Health needs assessment

- Strategic planning

- Contracting

- Any additional areas of contribution

6a. What opportunities do you feel community nursing practitioners have to influence commissioners in terms of determining public health priorities?

Opportunities

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-
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Further comments

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7. Can you describe any examples of, what are in your view, good public health nursing practice, in your organisation? (Please refer to the description on Page 1.)

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8. List any posts which have a substantial public health nursing remit in your organisation or specified in your contract intentions:

Please describe their role

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- 3

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- 4

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- 5

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9. What projects are you involved in, which you see as promoting public health services? (You may need to consult with operational colleagues to answer this question)

Please state in order of priority

1) Project Title

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Agencies involved

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Funding Body

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Key Objectives

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Role of health professional involved

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2) Project Title

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Agencies involved

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Funding Body

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Key Objectives

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Role of health professional involved

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3) Project Title

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Agencies involved

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Funding Body

.....

.....

Key Objectives

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Role of health professional involved

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Please use separate sheets if necessary to complete this question

10. In order that Trusts, Health Authorities and Primary Health Care Teams can be supported in this work, we would like your views on the barriers to developing public health nursing and your ideas about what would help to overcome these barriers.

Barriers:	**What helps:**
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8

11. Thinking about the Directorate of Public Health in your Health Authority: Please give up to three examples which highlight the way the directorate sees public health nursing. This might relate to contracting intentions, training courses, membership of working groups, senior posts etc.

- 1

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- 2

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- 3

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12. How are the community nursing practitioners contracts specified with Health Authorities in relation to public health?

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Please enclose copies of any appropriate contracts which illustrate specifications, if you are happy to do so.

13. Please give any examples of audit, research and outcome measurements being undertaken in your organisation.

Describe how you **assess** and **evaluate** the benefits of public health nursing detailing any associated issues.

Audit

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-

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Research

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Outcomes

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Evaluation

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SECTION FOUR

Education

14. How do you feel about the New Specialist Community Nursing Practitioner Course in terms of meeting the present and future public health remit?

Please discuss

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Please feel free to make any additional general comments in the space provided below:

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Do you within your Trust/Health Authority have a named person who has clinical responsibility for developing nursing practice around public health?

Please tick the appropriate box

YES ●

NO ●

If yes, please state who this person is, in order to facilitate further research in Strand Three if appropriate.

Name/Title .....

Contact Number (if permission is sought) .....

Please complete the details requested below to enable the research team to clarify who completed this questionnaire.

Questionnaire Completed by:-

Name .....

Title .....

Name of Trust/Health Authority .....

Thank you very much for your time

QUALITY EDUCATION · ENB · FOR QUALITY CARE ·

FORTY-ONE

JULY 2000

research HIGHLIGHTS

Evaluation of the Developing Specialist Practitioner Role in the Context of Public Health

Research Team Members

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- Paula Mead (Research Associate)
- Anne Graney (Research Associate)
- Gill McRae (Project Administrator)

University of Northumbria at Newcastle:-

- Professor Jan Reed (Professor of Nursing)
- Kath Johnson (Senior Lecturer)

Steering Group

- Dr Kate Billingham: Director of Public Health Nursing/Senior Research Fellow, Sheffield Health Authority (Chair).
- Margaret Ayton: Commissioning Manager/ Nursing Adviser, Newcastle & North Tyneside Health Authority.
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- Professor Jean McIntosh: Professor of Community Nursing Research, Glasgow Caledonian University.
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- Professor Sue Procter: Professor of Nursing Research, University of Northumbria at Newcastle.
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Abstract

This study examined the preparation of community specialist practitioners (health visitors, district nurses and practice nurses) for public health work, and how this is used in practice. There were three parts to the study: National postal surveys were completed (1) for course providers and (2) for practice settings (Health Authorities and Trusts). (3) A case study approach was used in four districts to look at how education translates into practice. Public health work is seen as difficult to define, and not 'core' work by nurses. It tends to take second place to work which is more concretely measurable. Practice-based learning is viewed as important. Community Practice Teachers are a key influence. It is concluded that effective practice-based learning should be developed and strategies explored to support public health work alongside more immediate health care demands.

Main Findings

Strand One: Educationalists

The people who ran courses leading to community specialist practice qualifications felt that the main public health priority was about targeting poverty and inequity in terms of employment, housing, education and health care provision. For everyone except those running district nursing routes, health promotion was a strong common theme in provision. District nursing leads tended to prioritise disease prevention. Programme strengths were identified as rooted in shared learning through inter-professional collaboration and good clinical links with community practitioners and community practice teachers. The main weaknesses identified appeared to be around the problems of integrating theory and practice. Shortage of time to deliver the programme adequately was seen as adding to this difficulty. National policy documents featured most strongly as influencing preparation, however, a range of literature from professional and educational bodies was also mentioned. The strongest identifiable public health function across all disciplines was health needs assessment. However, there was great variation in the level of detail described and the prioritisation of issues.

Strand Two: Health Authorities and Trusts

The data mainly reflects the views of senior nurses working in Trusts. The major influence in determining public health priorities was seen as the information and direction received through national documentation. Local priorities were often determined through targeting of specific groups, pregnant teenagers and ethnic minorities or refugees often featuring strongly. The key functions of the public health nursing role were seen as health needs assessment, health promotion and service and policy development. Obstacles and opportunities to public health work were also explored for each group. Lack of resources (both time and money) was highlighted as an obstacle by many respondents, closely followed by employers' attitudes. Opportunities lay in the interdisciplinary nature of primary health care, and in existing patterns of access to populations. Public health posts in practice were identified as including both specialist posts (for example TB nurses, AIDS specialists, accident prevention health visitors, infection control and communicable disease nurses mainly, but a large range of posts mentioned) and 'community nursing' posts (mainly described in terms of health visiting and school nursing, although district nursing was mentioned). Factors facilitating public health nursing were seen as diverse. Four areas dominated responses. Respondents wanted more emphasis on multi-disciplinary training for public health, more secure funding, policy guidance with clear aims and objectives, and greater collaboration.

Strand Three: Case Studies

At all sites, respondents found it difficult to articulate what public health work might be, though all provided examples of public health practice. The balance between University based work and learning in practice was seen as important, with the models of public health available in the practice setting seen as central to learning. Community Practice Teachers were seen as a key influence on students' practice, but in their own practice struggled to balance public health work with other responsibilities. Public health work was seen by them as 'add-on' work, not highly valued by colleagues and managers. Time was seen as a major constraint to effective learning.

Outlining their concept of 'public health' proved to be a challenge for almost all respondents. Responses could be described on two axes (see Figure 1). The first of these lay between individual and collective activity. The second spanned a continuum from infection control or 'hygiene' on the one hand to community empowerment on the other. The various practitioner groups can be provisionally located on this two-dimensional outline.

Despite difficulties in explaining exactly what public health might mean as a concept, a majority of respondents appeared to have no difficulty in describing public health activity in which they were involved. The activities described ranged widely, from domestic violence support to prevention of falls in older people. It was however clear that a considerable proportion of the examples cited were either still at the planning stage, or had met with apparently insurmountable problems in moving them forward. Many of these had related either to available time or to other resource. The few which had got off the ground had been subject to some evaluation but the outcomes examined had largely been 'soft'. However, it was noted that in contrast 'mainstream practice' was usually not evaluated at all. The health benefit cycle has been suggested (SNMAC 1995) as a framework for evaluating methods and systems for promoting health in communities. The cycle consists of seven key steps. These were examined in relation to the examples provided:

1. Defining the health problem

   All of the examples put forward incorporated at least a brief definition of a specified health problem - for example teenage pregnancy, toddler behaviour problems.

2. Identifying potential solutions

   In each case one or more potential solutions had been identified, often, but not always involving the development of a group, or use of local networks.

3. Agreeing health priorities and outcome objectives

   Agreement of health priorities was generally implicit rather than explicit - for example in the prioritisation of resource for toddler behaviour management.

4. Specifying interventions and standards required

   Where individuals described detailed planning processes it appeared that this would produce a more clearly specified intervention - as for example in the case of the domestic violence helpline. Clear standards were not always specified.

5. Delivering the interventions

   Relatively few examples had reached this stage.

6. Auditing the processes of delivery against the standards specified

   As stated above, where initiatives had progressed into action, evaluation was quite common, though often relatively 'soft' - for example asking attenders their views of the initiative.

7. Re-assessing the health problem after delivery of the intervention

   Where impact had been less than anticipated, modifications to approach were proposed - for example in looking at healthy eating for young people, changing the target group slightly.

The major barrier to undertaking public health practice was seen as the pressure to undertake mainstream, 'hands on', practice. The Community Practice Teacher was seen as having a key role in bridging the theory-practice gap, and helping students to see how University based teaching made sense in the practice context. Where students remained locked into 'hands on' models, learning was about *"getting [them] to stand back"*.

Learning about Public Health Work - An Outline Model

An outline model is described in Figure 2 which offers a way of describing the inter-relationship between factors identified at different points in the educational process as impacting on learning about public health work. Firstly, many respondents talked about the student's prior knowledge being an influential factor in their learning. The students themselves experienced time as a constraint in acquiring knowledge, skills and attitudes and in gaining experience of practice. The curriculum was delivered substantially by lecturers who found it relatively easy to articulate their notions of public health, but harder to describe practice. The lecturers saw their role as helping students to 'see' public health work, and enabling students to believe that they were *able* to make changes in people's health experience. Community Practice Teachers on the other hand perceived their role as constrained by the demands of practice, and the need to balance 'mainstream' community nursing or 'bread and butter' health visiting with public health. Community Practice Teachers were responsible for providing students with an appropriate framework within which to progress the development of a public health role. One of the most common frameworks used was the principles of health visiting, which respondents adapted to their own needs. The practice environment in which learning occurred was noted by many respondents to offer different opportunities if it was urban or rural, affluent or poor.

Transformation takes place from student to practitioner. There is then an informal period of consolidation - seeking to make sense of practice and get to grips with what is required. Similar issues arise in looking at consolidation as in the initial course time. The frameworks which have been provided continue to be used. The environment in which the new practitioner works offers opportunities for public health work which may be few or many. The resources available to develop public health work in this period also contribute to the new practitioner's development of activity in this area. The time available to the practitioner is her key resource, and respondents make clear that 'bread and butter' health visiting at this stage will often be time-consuming. However, if there are active voluntary groups, or established workers with whom to collaborate, as in some of the examples given, newly qualified practitioners will begin to plan for, and sometimes undertake, public health activity.

Discussion

Public health work is not generally seen as 'core' work by community specialist practitioners, even health visitors. It tends to take second place to mainstream practice and areas of work which are more concretely measurable. How can the status of public health be raised, and in particular, where resources are finite, how can public health work be supported alongside more immediate health care demands?

The concept of public health is constantly

changing. This requires those working in public health to possess skills which can grow and develop to meet needs as they emerge - flexible and transferable skills. In addition, the environment in which learning takes place and the resources available must be assessed in the light of current approaches to public health. Course Programme Directors and others will need to address how best curricula can enable practitioners to obtain a flexible portfolio of skills.

Community specialist roles remain in transition. Different disciplines have different perceptions of public health, suggesting that they might apply core skills in different ways. A review should examine how far the core skills required are held and used in common. Students learn to do public health work through learning to see 'the wider picture'. Though Community Practice Teachers appear more influential in shaping public health practice than lecturers, they are not always supported in this task. Further work is required to explore how CPT support is best done. In addition, post-qualification support in developing practice must be addressed.

Conclusion

This study has examined how far programmes of education can successfully prepare community nursing specialist practitioners to carry out a public health role, and some of the factors which act as aids and hindrances in the translation of theory into public health practice once they are qualified. Practice examples were reviewed in relation to the health benefit cycle. They generally conformed to the early stages but were not precise. In curriculum documents, learning objectives of relevance to public health were few.

The study team looked at how current and future specialist roles might develop and considered students', course teams' and service managers' perceptions of current and future public health roles. The research team also considered the implications of potential developments in post-registration education on public health for pre-registration education and practice, and discussed the implications of the Peach Commission's recently published report (UKCC 1999). Prior experience in community settings appeared to be important in further learning about public health work. Incorporating interdisciplinary learning within curricula would provide a strong base for collaborative working. Developments in practice based learning and assessment may be transferable from other settings to deal with issues raised in relation to community specialist courses and in particular, to span the theory-practice gap.

Box 1 Illustrative Quotations

"All you're doing is sowing the seeds of what they could do when they get out there with their own workload, drawing their attention to the possibilities that they could become involved in." CPT

"...I think you are influenced a lot by the CPT, because you put them on a pedestal and see them as someone very knowledgeable, they do it every day, where someone from college comes in for a couple of slots that week." Student

"Workloads and caseloads and referrals, people having to prioritise in terms of their time, what they can delegate and what they can't delegate, so I guess that's the main barrier." Professional Lead - District Nursing

"In a lot of the trusts around here there is still that medical model so that what they are employed to do are things like developmental assessments and running baby clinics and you know visiting new mums. Now I'm not demeaning that in any sense of the word but that is the contractual bit and appears on job descriptions... They don't see the public health role as being part of the top agenda for health visiting and that is a trust problem." Lecturer

"Political with a small p, things like housing, things like poverty affecting all of those groups... That is really strong for me but I don't know whether our employer would see that as public health." HV

"It was very difficult to get her to actually see what public health was because she was much more still, I felt then, in a sort of clinical role, she had come from midwifery and felt that a hands-on approach was what was wanted." CPT

"I feel part of the training is being able to present, to put things over clearly... a lot of public health is actually being able to change people's ideas or influence them, the uptake of things, and I think you have got to be quite good at communication to get that across especially to GPs." CPT

"In an ideal world we would all like to work differently I think but at the end of the day there are things that you have to get done and the routine child health surveillance is the thing that takes priority." HV

"[there are health visitors who are] in effect public health beacons, but I get the impression that that is not what they were trained to do and they have this kind of subversive look to them, and if they're not properly doing their job, they're doing another job." Director of Public Health

"I know they are supposed to learn that... but I think it's got to be reinforced because once they start getting into their caseload and going to the universal screening and things like that... they don't always actually lift their heads up and look at the real needs of the population." Locality Manager

Figure 1 – Location by Discipline on a Public Health Continuum

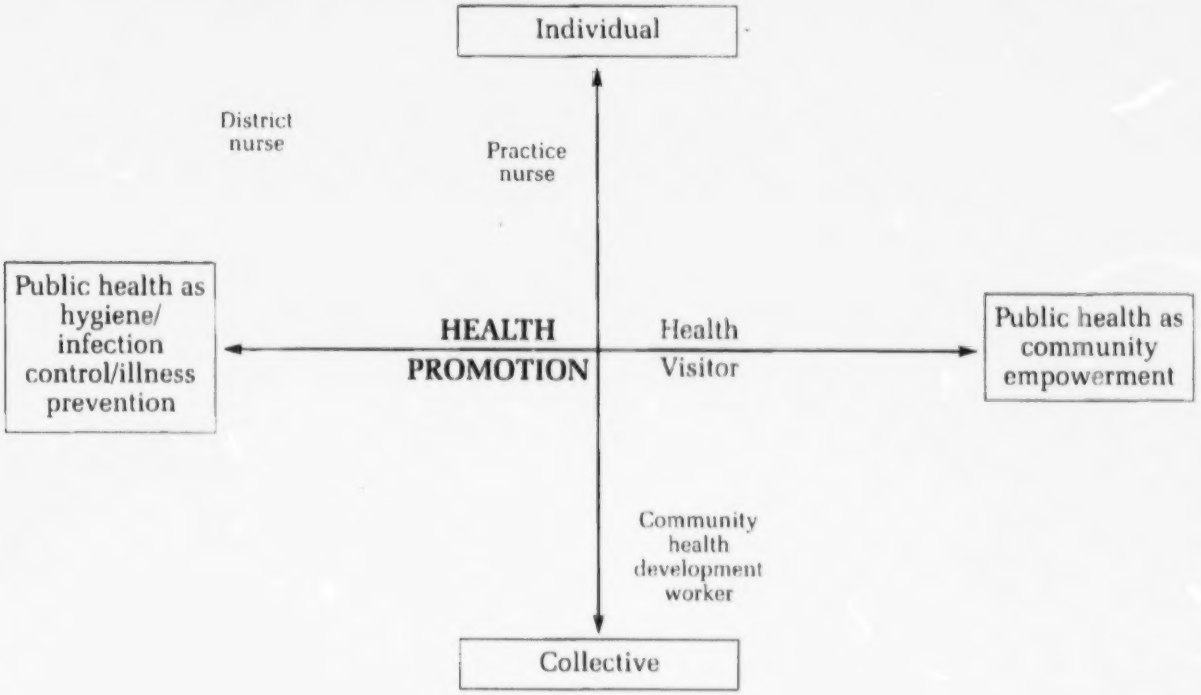
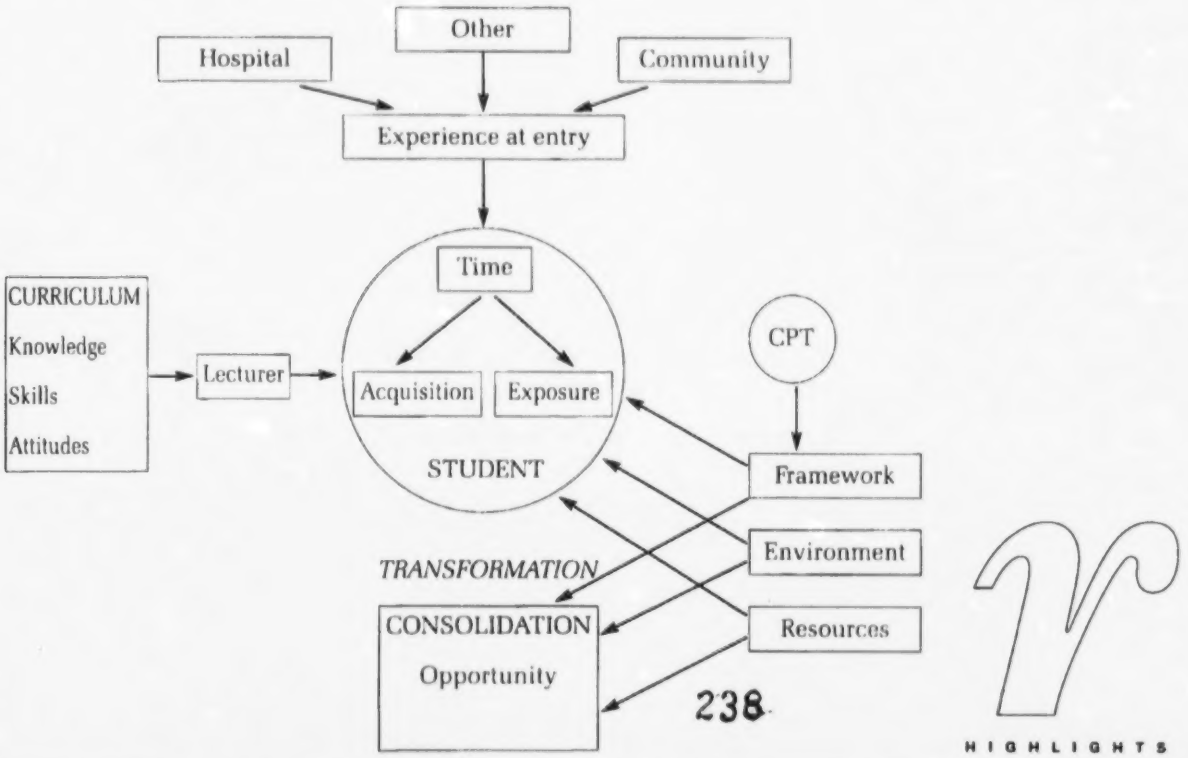


Figure 2 – Learning about Public Health Work



Further information

For copies of the Research Highlights and the Report, please contact:
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Method

The study was designed in three strands. The first two, looking at courses and practice settings, sought to provide a broad overview of developments in public health nursing. The third strand used a multiple case design, with each case selected to offer a different perspective on the phenomenon of 'education into practice', bringing together educational and practice settings, practitioners and students, to allow a more detailed exploration of the processes of curriculum delivery and practice development.

Strand One was a questionnaire based survey of course programme directors (n=10) and route module leaders (n=42) from community specialist programmes. Strand Two collected the views of senior nurses in each Health Authority and Trust in England (n=109) about public health work in community specialist nursing. For Strand Three of the study data was gathered at each site using focus groups and individual interviews (n=76) as well as public health incident logs, curriculum documents and local policy documents. The data gathered looked at respondents' perceptions of public health, the nature of the educational experience of the students in relation to public health, and the way in which this was translated into practice, together with factors which acted as barriers or levers in the latter.

Details about the Project

Commissioned by the English National Board for Nursing, Midwifery & Health Visiting, and part-funded by the UKCC, this project was undertaken jointly by the University of Newcastle and the University of Northumbria at Newcastle. It commenced in April 1997 and was completed in September 1999. It was designed in three strands. Strands One and Two were national questionnaire based surveys, of educationalists and Health Authorities/Trusts respectively. Strand Three used a multiple case design to examine the phenomenon of 'education into practice' for public health. The study's findings will be useful to those responsible for developing or delivering non-medical education programmes for public health work, and to community specialist practitioners exploring or working in public health.

References

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